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DIAGNOSIS, PROGNOSIS AND TREATMENT OF MITRAL STENOSIS.*

BY J. T. ESKRIDGE, M. D.,

Physician to the St. Mary's and Jefferson Medical College Hospitals.

The mitral presystolic murmur, although standing about fourth in point of frequency of endocardial murmurs, is, nevertheless, of sufficiently frequent occurrence to be recognized by everyone at all familiar with cardiac auscultation. The mitral presystolic murmur and its diagnostic characters were first clearly pointed out by Fauvel, in 1842, (vide article by Flint, the *American Journal of the Medical Sciences*, April, 1882).

Two varieties of this murmur have been described. One variety, by far the more frequent, characterized by Flint as vibratory or blubbering, is rough; the other is soft or "bellows-like." Fauvel described the former, and Walshe and Markham the latter variety of the murmur. Flint says: "A soft mitral presystolic murmur is a very rare physical sign. A rough mitral presystolic murmur, on the other hand, is by no means rare." To support his view of the frequency of the latter murmur, he observes: "From 1858 up to the present time (1882) it is not an exaggeration to say that many hundreds of examples have come under my observation during this period, in hospital and private practice. Prior to my publications just referred to," (vide Flint's work on "Diseases of the Heart," 1852, and the *American Journal of the Medical Sciences* for 1862) "so far as I know, no writer in this country had described this murmur. I believe that I may add that for many years after those publications it was not recognized as a distinct murmur but by very few of those who gave mor or less attention to anscultation, and, indeed, at the present time (1882) it is not so recognized by many."

Contrary to the views expressed by Hope, Walshe, Markham, Flint, and others, Hayden, in his exhaustive treatise on "Diseases of the Heart and Aorta," says: "I have already stated that the murmur of mitral obstruction is harsh and unpleasant to the ear; I have never met with an example which constituted an exception to this statement, notwithstanding that Markham maintains that softness is a quality essentially characteristic of presystolic murmur." My own experience is nearly in accord with the statement found on page 216, vol. I. of Hayden's work just referred to. It reads: "The quality of the presystolic murmur is always more or less harsh, and usually decidedly so." In the numerous examples of mitral presystolic murmurs which have come under my observation, the accuracy of the diagnosis in many of these cases having been verified by *post mortem* examination, I have not met with a single instance of a soft mitral presystolic murmur. The quality of the mitral presystolic murmur, in my experience, has varied much, all so far having been more or less harsh, while the larger portion have been decidedly so. In every case that has come under my care, presenting mitral direct and regurgitant murmurs, the presystolic has been harsher than the systolic murmur. I do not wish to be understood as say-

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ing that a soft mitral presystolic murmur never occurs, but only, that I have never met one.

Speaking from personal experience, I have found mitral stenosis complicated with mitral insufficiency in about two-thirds of the cases; others state that the association of both mitral lesions occurs in a still greater proportion in mitral obstruction. Hayden thinks that about one-half the mitral obstructive lesions are unattended by mitral regurgitation.

In the diagnosis of mitral stenosis a presystolic murmur and purring thrill are the physical signs of most importance. The quality of the murmur, as I have heard it, and as most authors have described it, is more or less rough, and in the majority of cases very decidedly so. Possibly, in a few instances the murmur is soft, but it must be exceedingly rare, as I have never met with a single example of it, although about forty of the harsh variety have come under my observation during the last eight years. The mitral presystolic murmur, whatever be its quality, begins before the first sound of the heart, and ends when the latter begins. It never occurs with the first sound, whereas a mitral regurgitant murmur is never heard before the first, but always synchronously with it. The mitral presystolic murmur is harsh, begins rather abruptly, increases in loudness, and ends suddenly while the ear is intent on listening for its continuation. The carotid pulse, and apex beat of the heart can be felt to follow the presystolic murmur. If attention is paid to this, when both mitral presystolic and systolic murmurs are present, these may be observed to be separated by an appreciable interval of time. Under such circumstances the harsh, abrupt ending of the presystolic will be in marked contrast to the gradual lessening of the loudness of the systolic murmur. Moreover, in the majority of cases, the former murmur will be found to be harsher and more unpleasant to the ear than the latter.

If now the stethoscope be placed in the left axillary region, the systolic murmur, if not louder in this position, will be frequently more clearly defined, while the presystolic murmur will have disappeared or become very faint. In some cases in which both mitral murmurs have been present, I have been assisted in differentiating the murmurs by comparing the stethoscopic observations made over the præcardial region with those observed at the lower angle of the left scapula. In the former situation, the systolic murmur is preceded by an abrupt, harsh murmur, which ends suddenly; in the latter position, with infrequent exceptions, is heard only the systolic murmur, which neither begins nor ends so abruptly, nor except in probably rare instances, is as harsh as the first part of the murmur heard anteriorly.

The abruptness of the ending of the mitral pre-systolic murmur is easily understood when we remember that the current of blood which gives rise to it, passing through a narrowed auriculo-ventricular orifice, is suddenly reversed during the ventricular systole.

The mitral presystolic murmur is most intense about the left fourth costal cartilage, or just above, and a little to the right of the apex beat. It is absent or faint at the base of the heart, especially at the right base, is rather infrequently heard in the left axillary region, and some writers on physical diagnosis say it is never heard posteriorly at the lower angle of the left scapula, although Hayden states that in one instance he heard the presystolic murmur in the last position.

When a presystolic murmur exists, is it easy to diagnose it? Dr. James Andrew states that "it must be confessed that the diagnosis of a presystolic from a systolic ventricular murmur is one of the most difficult tasks in the physical examination of the heart, and is often all but impossible." (Hayden on Diseases of the heart and Aorta, p. 202). Flint observes: "It may be said of a truth that when its distinctive points have been fully understood and verified by examples, no one of the cardiac murmurs is more readily recognized than the mitral presystolic murmur." (The *American Journal of the Medical Sciences*, April, 1882.) On this point Flint is in accord with most observers who have given special attention for a length of time to the diagnosis of mitral stenosis. Of late my experience has been, when the heart is not acting very rapidly or tumultuously, that I have not encountered much difficulty in satisfying myself of the presence or absence of the mitral presystolic murmur. This murmur, more than all others, requires for its appreciation, clear recognition of the cardiac sounds; if the heart, therefore, be acting so rapidly or tumultuously that its systole and diastole cannot be defined, it is impossible to diagnose this or any other heart murmur, although a loud one may be present. To be able to readily distinguish the presystolic from the systolic murmur requires very careful training of the ear to appreciate the rhythm of endo-cardial murmurs.

Hayden calls attention to five conditions which may give rise to murmurs simulating the mitral presystolic murmur. With proper care, all these

sources of error, as he clearly points out, may be avoided.

Is mitral stenosis always accompanied by a presystolic murmur? Walshe says, "the murmur is frequently absent."

"Dr. Waters believes that presystolic murmur is far more frequently absent than present, even when there is great obstruction at the mitral orifice." (Diseases of the Chest, second edition, 1873, *vide* Hayden on Diseases of the Heart and Aorta, 1875).

DaCosta says: "Undoubtedly there are instances in which no murmur reaches the ear to show that the valves are damaged. All the instances I have met with of valvular disease, unaccompanied by blowing sounds, have been instances of diseases at the mitral orifice, and of extreme narrowing of that orifice. They were all attended with excessive irregularity of the action of the heart, and with hypertrophy. They all produced difficulty of breathing. They all presented this peculiar clacking sound most marked near the apex." .(Medical Diagnosis, DaCosta, 3d edition.)

Flint states that "It is by no means true that a rough mitral presystolic murmur is present whenever an obstructive mitral lesion exists. A mitral obstructive lesion may be found after death, when a mitral presystolic murmur had not been produced." Flint thinks when the mitral murmur is absent, a mitral stenosis existing, that the obstruction is due to "contracted, thickened, or calcified valves," incapable of being set in vibration by the current of blood from the auricle into the ventricle. In reference to the presence of a mitral presystolic murmur in mitral stenosis, Hayden's propositions (*c*), (*d*) and (*e*) read as follows:

"(*c*) That it is never permanently absent in cases of this lesion;

"(*d*) That it is very seldom temporarily absent in such cases;

"(*e*) That in these exceptional instances, the explanation of its absence is almost invariably to be found in debility of the heart." (Diseases of the Heart and Aorta, p. 904.)

Dr. Balthazer Foster observes: "A special peculiarity of the presystolic murmur is its variability: it is the only organic murmur which disappears and reappears as the heart conditions change. For instance, a murmur, inaudible while the patient is at rest, is developed by a little exercise; or again, an irregular tumultuous action of the heart masks all murmur, which becomes distinct as the heart steadies down under digitalis." (Dictionary of Medicine, Quain, 1883.)

It will be observed that Hayden lays great stress on the presence of a mitral presystolic murmur, and believes that it is never absent except in cases with extreme feebleness of the heart. Flint, while admitting its absence from the feeble condition of the heart late in the disease, thinks the character of the valve lesion accounts for its absence in some cases, the valve being in the cases in which no murmur is present at any time, incapable of vibrating on account of the extreme rigidity of the leaflets from calcification, etc. Of the six cases coming under my observation, in which the post-mortem examination showed mitral stenosis, the murmur was absent in only one individual. In this patient, during my attendance on her, general dropsy and great pleural and pericardial effusion existed, with a feebly acting heart. Hayden says, "in two cases only out of a total of eighty-one, or in the proportion of 2.4 per cent. was the murmur actually suspended, under any personal observation, yet in both of these it was resumed after a brief interval." Of his fatal cases (fifteen) the murmur was not heard by him in three; these, for the most part, presented themselves to him after the circulation had become very weak. In three cases in which no mitral presystolic murmur was heard, I diagnosed mitral stenosis from the presence of thrill and associate symptoms. The correctness of the diagnosis in these cases has not been verified to my knowledge by post-mortem examination, or even the development of a murmur.

Is a mitral presystolic murmur present only when mitral stenosis exists, or, in other words, is the murmur pathognomonic of mitral obstruction? Here, again, authors differ. Flint says, "A well-marked, rough mitral presystolic murmur may be present, and not be due to any mitral lesion." I am not aware of this clinical fact having been stated by any other medical writer. It was stated in my article on the Cardiac Murmur, in 1862, and I have reiterated it in subsequent writings. In the article just referred to, I gave the synopsis of the history of two cases in which the presystolic murmur was noted during life, and no lesion at the mitral orifice sufficient to account for the murmur found after death. I have met with several instances since that time. In all, there existed aortic lesions which occasioned free regurgitation." (*The American Journal of the Medical Sciences*, April, 1882). Flint's observa-

tions, although first published about twenty years ago, so far as I am aware, have not yet been verified. I have met with only one case in which an aortic regurgitant murmur was associated with the mitral presystolic murmur. In that instance, the aortic valve was incompetent, and the mitral orifice was very much contracted. Flint's explanation of the occurrence of a mitral presystolic murmur without mitral stenosis is, to say the least, ingenious, although it has not escaped criticism by Hayden. Dr. Hilton Fagge, whose memoir was published in 1871 (Hayden on Diseases of the Heart and the Aorta), seems to have entirely overlooked or disregarded the observations of Flint. Fagge states: "Hitherto, I believe, no single instance has been recorded in which a presystolic murmur has existed during life, and in which the mitral orifice has not been found after death to be very decidedly narrower than usual." "Dr. Balfour declared his opinion in 1871 that presystolic murmur 'may be conclusively accepted as distinct proof of the existence of a permanent deformity, even though the murmur itself should subsequently disappear, as it frequently does.'" Hayden remarks: "Judging strictly within the limits of my own experience, and drawing my conclusions from statistics given, I feel justified, therefore, in holding,

"(*a*) That presystolic murmur is pathognomonic of auriculo-ventricular narrowing;

"(*b*) That it is never present where auriculo-ventricular narrowing does not exist;

"(*c*) That it is never permanently absent in cases of this lesion."

Foster says, the pathognomonic sign of mitral stenosis is "a murmur preceding the systole and ending with its commencement."

It is my habit to examine the heart of nearly every one coming under my care, no matter what the character of the illness, but I have not yet met with a case presenting the mitral presystolic murmur, the heart of which was examined after death, that did not reveal mitral obstruction.

I have found the mitral presystolic murmur to vary much in loudness from time to time, but I do not think I can name a single instance of the entire absence of this murmur after it had become fully developed, except during the conditions mentioned by Hayden.

THRILL.—The fremitus or purring thrill of mitral stenosis is best felt in the fourth intercostal space and immediate neighborhood of the apex beat. It is distinctly presystolic, differing widely from the extremely rare thrill of mitral insufficiency, the latter always being systolic. Fothergill states, "the thrill is often absent, but when present, is of great diagnostic value, and marks the case as one of stenosis." ("The Heart and its Diseases," Fothergill). Hayden observes, the thrill "is frequently absent when murmur announces, in the most positive manner, that mitral narrowing actually exists. Out of the total of eighty-one cases, it was present only in forty-one instances; and of the fifteen cases in which death occurred, and the body was examined, it was noted in six only." ("Diseases of the Heart and Aorta," Hayden). The fremitus of mitral narrowing is sometimes simulated by a pericardial friction fremitus, but a mistake in diagnosis may be avoided if proper precautions are observed.

Other physical signs may be present to aid in the diagnosis, but if thrill and murmur are both absent, they are rarely of sufficient value to establish the diagnosis of mitral stenosis.

The first sound of the heart is shortened, intensified and frequently reduplicated; the second sound is feeble or absent at apex, but intensified at left base. (Dr. James Andrew, *vide* the "Heart and its Diseases," by Fothergill). It should be borne in mind that the pulmonary second sound becomes very feeble when the right side of the heart dilates sufficiently to admit of tricuspid regurgitation. Signs of dilatation of the left auricle appear comparatively early, and those of enlargement of the right side of the heart later. Pulmonary hemorrhage is more frequent in mitral stenosis than in any other variety of valvular lesion of the left side of the heart. Passive congestion of most of the internal organs takes place late in the disease. The majority of cases of mitral stenosis end in death before general dropsy results.

Prognosis of Mitral Stenosis.—If the prognosis and treatment of mitral valve disease are not modified by differential diagnosis between constrictive and regurgitant lesions, we should scarcely be justified in devoting so great attention to mitral stenosis apart from mitral incompetency. On these points Forthergill speaks with considerable force. "It is," he says, "unfortunate that so much stress is laid at present upon the diagnosis of the two forms of mitral murmur, because the recognition of the exact lesion does not bear much upon either prognosis or treatment, authorities differing as to whether the prognosis of stenosis or regurgitation is worse; and agreeing that in both cases the correct plan of treatment is to build up the right heart by the administration of digitalis, iron, etc. The day of the prominence given

to the presystolic murmur will ere long be over."

Such an assertion coming from so good authority deserves due consideration, yet, I think, it is too sweeping, and should not be blindly accepted.

Dr. Sansom, of London, thinks it is rare for mitral obstructive lesions to be of so long a duration as some cases of mitral regurgitation.

Dr. Flint says: "A rough presystolic murmur may represent a degree of mitral obstruction which may be tolerated for years." (The *American Journal of the Medical Sciences*, 1882). Three of his cases have extended over periods of ten, twelve, and fifteen years respectively.

Lesions of the mitral valve, regurgitant and constrictive, may be divided into two classes. The first class should include those lesions that do not materially interfere with the function of the heart; unknown to the patient, are unattended by any special symptoms, and never compromise comfort or life to a great extent, unless an individual whose heart is thus affected, should suffer from some exhausting disease, which may weaken the heart and cause the valve to reinflame. This form of valvular disease is frequently only accidentally discovered.

The second class includes all those constrictive and regurgitant lesions which cripple the heart and destroy life.

We can the more readily appreciate the relative prognosis of mitral stenosis and regurgitation, by studying the sequential lesions of each form of mitral valve disease. It is unnecessary to bring forward statistics to prove that lesions of the tricuspid valve admitting free regurgitation more speedily result in death than a similar lesion at the mitral orifice. It is the common experience of most physicians who have met with tricuspid regurgitation, to find the cavities of the right side of the heart to enlarge by dilatation and hypertrophy, and blood stasis with pulmonary œdema, and general dropsy, to take place, followed by death in the course of six months to two years.

The sequential lesions of mitral stenosis, as stated by all who have given much study to the subject, and as first pointed out by Dr. Adams about fifteen years before the mitral presystolic murmur was described by Fauvel, are as follows:

When the mitral orifice is sufficiently constricted to decidedly obstruct the flow of blood from the auricle into the ventricle, the auricle is compelled to contract more forcibly to empty itself. At first, slight hypertrophy of the auricle takes place, but its thin wall soon begins to yield to over-distension, and then dilatation out of all proportion to the hypertrophy results. At this stage, when the weakened and dilated auricle is unable to propel its contents through a small orifice in the time allotted for its systole, the pulmonary circulation begins to suffer, and, in turn, the right ventricle, compelled to contract upon a larger quantity of blood than usual, also begins to enlarge by hypertrophy and dilatation. While the right ventricle is still strong, the left auricle being dilated, the lungs suffer most, hence blood-spitting, cough, dyspnœa on exertion, and liability to take cold on exposure, are well pronounced. This condition of things soon produces lowered vitality, and the right ventricle, in which hypertrophy for a time kept pace with the dilatation, dilates from distension and weakness of its wall, until, at last, tricuspid regurgitation results, followed ultimately, if the unfortunate sufferer live long enough, by general dropsy. The left ventricle, provided no mitral insufficiency coexists, remains nearly normal or slightly atrophies.

The first of the sequential lesions of mitral regurgitation is seen in the left ventricle. This portion of the heart, for a long time, if no undue strain is put upon it, hypertrophies sufficiently to enable it to compensate by its increased power of contraction for the loss of blood through the mitral orifice. As the left ventricular wall is quite thick and strong, compensation is possible so long as the patient is well nourished, and avoids everything that over-works the heart. Loss of compensatory hypertrophy is usually due to over-exertion, mal-nutrition, and depressing influences, resulting in dilatation and degeneration of the ventricular wall. In speaking of mitral valve lesions, Flint observes: "All the symptoms and effects referable to the respiratory system are more marked when the lesions are obstructive than when they are only regurgitant." (Diseases of the Heart.) "Hope remarks that he had met with pulmonary apoplexy more frequently in connection with great contraction of the mitral orifice, with or without hypertrophy of the right ventricle, than in any other association." (Diseases of the Heart and Aorta, Hayden.) In some cases of mitral regurgitation, the lesion is so extensive and the loss of blood so great that it is impossible for compensation to be established by hypertrophy of the left ventricle.

Mitral stenosis and regurgitation existing together make the prognosis more unfavorable than when one of these lesions exists alone. Compensation seems to be better effected in mitral regurgitation when aorta valve lesions

co-exist. It has not been my experience to find the same benefit result from aortic valve disease in mitral stenosis.

Hayden believes that the longer the mitral presystolic murmur the greater the obstruction, and hence the graver the prognosis. It is in such cases that he has found associated the postdiastolic and presystolic murmur.

TREATMENT.—In the few words that I shall devote to the treatment of mitral stenosis, I shall not discuss those measures that seem to me equally efficacious in both mitral obstruction and regurgitation.

Rest in the recumbent posture.—In those cases in which mitral obstruction is giving rise to inconvenience, rest from time to time in the recumbent posture, I have found to aid greatly in relieving the pain and sense of constriction around the heart, symptoms which, as a rule, are more pronounced in mitral constriction than in regurgitation.

Avoiding stimulus.—Total abstinence in many cases may be observed. Irritability of the heart is always well marked late in the disease, and alcohol frequently increases this. If any stimulus is given, it should consist of the lighter wines. This course is applicable to cases of mitral regurgitation, but until late in the disease, does not seem so imperative.

Protecting the body from sudden changes of temperature.—When it is understood, next to the heart, the lungs suffer most from this form of valvular lesion, the importance of preventing chilling of the body will be appreciated. Hæmoptysis, pulmonary apoplexy, or pneumonia, may result from exposure to damp and cold. The chest, especially, should be well clad. As in pulmonary phthisis, a chest-protector should be worn during the cold season of the year.

Local treatment.—This consists of cups, dry or wet, leeches, blisters, and milder counter-irritants, followed by poultices, over the præcordium. Wet cups I have never used. Dry cups over the heart both early and late in the disease, give great relief. It has been my experience to find pericarditis, or pleuro-pericarditis, relatively more, much more, frequently associated with obstructive than with regurgitant lesions at the mitral orifice. It is in such cases that a few leeches over the heart, afford great relief. Local abstraction of blood is very beneficial when the heart is acting tumultuously on account of its cavities being over distended with blood. Counter-irritants, followed by poultices, afford a sense of comfort.

Special internal medication.—In mitral stenosis the auricle contracts ordinarily in too short a time to allow sufficient quantity of blood to flow into the ventricle through a narrow mitral orifice. By special medication we desire to slow and tone up the heart's contractile power. Digitalis slows the heart and increases the force of its contraction. It has been the remedy in these cases for a number of years, but to its use objections are not wanting; it frequently disagrees with the stomach, its poisonous effects are feared if we are compelled to continue its use too long, and moreover, some cases of mitral stenosis do not seem to be as favorably influenced by it, as most, if not all, of those of mitral regurgitation. Of late, much has been said and written about the use of convallaria maialis, or majalis, in the treatment of cardiac disease. Some have asserted that this old and new remedy in the treatment of dropsy is more adapted to the treatment of mitral obstruction than to mitral regurgitation. My experience with this agent is limited. The cases in which I have tried it have been desperate, and because I did not get satisfactory results from its use, I do not feel inclined to condemn it. I am glad to know that we shall be favored this morning with the results of Dr. Bruen's experience in the use of convallaria majalis.

In conclusion I may add, from a careful study of mitral stenosis, I have been led to believe: That it is often of some practical importance to diagnose the obstructive from the regurgitant form of mitral lesions; that the prognosis and treatment of mitral valve affections are more or less modified by the fact of whether the lesion be stenotic or regurgitant.

SCARLATINA: THE POSITION OF THE SYMPATHETIC NERVE IN ITS SYMPTOMATOLOGY AND BELLADONNA AS A MEANS OF THERAPEUSIS.

BY HENRY BEATES, JR., M. D.,

Of Philadelphia.

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(*Continued from page* 483.)

In scarlatina, as before mentioned, we have vaso-motor paralysis, and, notwithstanding the consequent increased elimination of heat, there is marked augmentation of temperature. Wood has conclusively proven that section of the medulla oblongata at its junction with the pons, results in increased heat elimination, and at the same time increased heat production, the increased heat dissipation not keeping pace with the increased

production, so that bodily temperature rises. Adjusting these facts with the knowledge we possess, that in scarlatina we have vaso-motor paralysis, and, at the same time, increased bodily temperature, it *seems* to be a logical conclusion, that the materies morbi of scarlatina while, paralyzing the vaso-motor centres, at the same time stimulates the caloric centre. This conclusion, while apparently true, is *inadmissible*, because the phenomena of heat increase, pyrexia, are all due to results, in their nature, PARALYTIC!—(I limit this statement to the conditions under consideration) —and we are compelled to admit that pyrexia is dependent upon the removal of an inhibitory influence, which influence is preëminently that of retarding, or rather controlling, chemical changes in the body that result in the production of caloric. Tscheschin, quoted by H. C. Wood, has proven the existence of such a centre. Here looms up the great physiological fact that nutrition, and all that is implied by the term, depends entirely upon the integrity of the nervous system! If we call to mind the manifestations of disturbed and perverted nutrition in scarlatina, and interpret the phenomena of adenitis, gangrene, and sphacelation, so common in the malignant type in which, as it were, the nature of the poison is magnified, we can not err in the conclusion that this disease is a manifestation of a grave *depressing influence* affecting the *nervous system* of organic life, *i. e.*, the sympathetic. When a sensory or afferent nerve is stimulated, a fall of temperature follows, as the influence affects some centre either in or above the pons. This law, enunciated by Prof. Wood (H. C.), it is desired to be especially remembered, as it possesses an important bearing upon the treatment of the disease under consideration; for if a *depressing* poison occasions the phenomena denominated scarlatina by influencing the sympathetic system, a remedy possessed of the power to *stimulate* this system should, when administered in proportion to the degree of intensity of the depressing cause, be capable of reëstablishing functional equilibrium, and dissipating the disease. Within certain limits this is a fact. Hitzig has conclusively proven that a caloric centre is located in the first cerebral convolution immediately behind the sulcus cruciatus. Wood has proven that *destruction* of this region is followed by enormous increase of heat production, and that STIMULATION of *it* results in marked *diminution* of calorifaction. This is emphasized!

To briefly state the points, now deemed proven, we have:

1. That heat elimination is controlled by the vaso-motor nervous system.

2. That paralysis of the vaso-motor system results in *marked cutaneous hyperæmia* and increased elimination of caloric.

3. That in scarlatina we have *paralysis* of the *vaso-motor* system, *marked cutaneous hyperæmia*, and increased elimination of caloric, but notwithstanding this, pyrexia.

4. That an inhibitory centre exists, situated either in the frontal cerebral convolution, or pons varolii.

5. That paralysis of this Hitzig centre is followed by enormous increase of heat production.

6. That agents of a depressing nature paralyze the vaso-motor centre, and also the region of Hitzig.

7. Stimulation of the inhibitory centre is followed by diminution of calorifaction.

8. That in scarlatina we have a poison that paralyzes or greatly curtails the operation of both the vaso-motor aud inhibitory centres, and that pyrexia must necessarily, in its peculiar mode, result.

It will be instructive to here quote the conclusions of Prof. H. C. Wood regarding fever:

"1. In health there is in man a fixed mean and a normal variation of temperature, having a regular rhythm, and this variation is beyond the control of all disturbing causes which do not force the organism beyond the condition of health.

2. The maintenance of normal temperature and its rhythm is dependent upon the nervous system, which, within certain limits, controls both the production and dissipation of animal heat.

3. So far as our present knowledge goes, the chief factor in controlling heat dissipation is the vaso-motor nerves, including, in man, such nerves as control sweat secretions; these nerves being able, by contracting the capillaries of the surface of the body, and by drying the secretion of the skin, to reduce the loss of heat to a minimum, and by a reverse action to increase it to a maximum.

4. The only nerve centre proven to exist capable of influencing the heat production without affecting the general circulation is situated in the pons or above it, and whilst it may be a muscular-vaso-motor centre, it is more probably an inhibitory heat centre. Of whichever nature it may be, it must act through subordinate centres, situated in the spinal cord.

5. Fever is a nutritive disturbance in which there is elevation of the bodily temperature, and also an increase of the production of heat by an increase of the chemical movements in the ac-

cumulated material of the body; this increase being sometimes insufficient to compensate for the loss of that heat which is derived directly from the destruction of the surplus food in the body, very little or no food being taken in severe fever. The rise of temperature in fever, is, therefore, not dependent altogether upon heat production, as in fever there certainly is sometimes less production of heat in the organism than there is at other times when the bodily temperature remains normal; also excessive heat production may occur even at the expense of the accumulated materials of the organism without elevation of the bodily temperature.

6. In fever a daily temperature variation occurs which is parallel to that seen in health, and differs from the normal variation only in having a higher mean.

7. In fever vaso-motor paralysis when produced is followed by an immediate fall of temperature, similar to but greater than that which is produced by a like disturbance in health.

8. The decrease of heat production which follows section of the cord is much greater in the fevered than in the normal animal.

9. The so called inhibitory heat nervous system is not paralyzed in fever, but is less capable than in health of answering promptly and powerfully to suitable stimuli. In other words, it is in a condition of paresis or partial palsy.

10. The clinical succession and phenomena of a febrile paroxysm, such as that of an intermittent, seem plainly to depend upon the nervous system for their arrangement and relation.

11. In most cases of fever, and probably in all cases of serious fever, there is a definite poison circulating in the blood, the poison having been found in the system, sometimes having entered the organism from without. Bearing these facts in mind, the theory of the causation of fever becomes, to my mind, at least, very plain. It is simply a state in which a *depressing* poison, or a *depressing* peripheral irritation, acts upon the *nervous system*, which regulates heat production and dissipation. Owing to its depressed, benumbed state, the inhibitory centre does not exert its normal influence upon the system, and consequently tissue change goes on at a rate which results in production of more heat than normal, and an abnormal destruction and elimination of the materials of the tissue. At the same time the vaso-motor and other heat-dissipating centres are so benumbed that they are not called into action by their normal stimulus, pyrexia, and do not provide for the throwing off the animal heat until it becomes so excessive as to call into action even their benumbed and depressed forces.

Finally, in some cases of sudden and excessive fever, as in one form of the so-called cerebral rheumatism, the enormous and almost instantaneous rise of temperature appears to be due to a complete paralysis of the nervous centres presiding over heat production and dissipation."

This extensive quotation is made in order that our present knowledge of pyrexia may be presented as succinctly as possible, and that the changes produced by experimentation and the phenomena attendant thereon may be compared with those dependent upon the effects of the materies morbi of scarlatina. All fevers do not present identical symptoms. Pyrexia, as such, however, accompanies many morbid conditions and processes; but in this special exanthem, the concomitant phenomena are preëminently attendant upon direct depressing influences exerting themselves upon the sympathetic, and the nature of the disease by its specific effect upon the function of this system is clearly shown, and its morbid affinity for this tract demonstrated. That the mode of onset may be clearly indicated, the following extract from my record of cases will be made:

H. W., male, æt. nine years, on December 14, 1882, arose apparently in his accustomed good health. He ate a hearty breakfast, and attended the morning session of school. At dinner he complained of no especial illness, but had no appetite. About 1 p. m. a pronounced epigastric pain developed, which, in a short time, was accompanied with vomiting. Emesis occurred frequently, proving a very distressing symptom. Thirst was insatiable, and every mouthful of water imbibed was promptly vomited. The gastric contractions were forcible and spasmodic. Fever became pronounced, and a marked tendency toward drowsiness developed. He was first seen about 5 p. m. He complained of sore throat. Head symptoms were negative, except mild delirium. Throat presented evidences of hyperæmia. A muscular exanthem was conspicuous upon the velum palati, and the faucial pillars reddened. Temperature, 101°; respirations, 23; pulse, 96. The slowness of pulse for the degree of pyrexia occasioned some doubt whether I was dealing with a probably coexistent diphtheria, but scarlatina, however, was diagnosticated, and treatment instituted accordingly.

December 15th, 9 a. m. Vomiting continued throughout the night until 2 a. m., then ceased until 7, when it recurred. An intense development of the characteristic exanthem had occurred,

being especially marked over the back. Angina troublesome. Epithelium of tonsils elevated by a subepithelial purulent-looking exudate. Pain during deglutition, severe. Temperature only 102.4: pulse 126, respirations 24. Delirium had continued throughout the night, and at times occurs this a. m. Gastric irritability still present. Thirst not so troublesome. 5 p. m. Emesis less frequent. Diarrhœa amounting to eleven evacuations of a watery or paralytic character. Epigastric pain (solar plexus) diminished. Angina more severe. Delirium not so marked. Temperature 105, respiration 28, pulse 148—numbness of hands.

December 16th, 10 a. m. Temperature 103.4, pulse 122, respiration 22. Slight cough. Pulmonary signs negative. Subjectively, angina is worse, objectively better. Emesis has ceased and diarrhœa diminishing. 6 p. m. Temperature 104.2, pulse 126, respiration 22.

December 17th, 9:30 a. m. Less delirium, past night. Considerable sleep. Angina much less troublesome. Temperature 101.7, pulse 120, weak, and degree of compressibility varying. 7 p. m. Temperature 103, pulse 108, respiration 20. Cough worse; angina notably less. Has noticed surrounding objects and asked for food. Only seven evacuations in twenty-four hours. Exanthem fading and convalescence entered upon. Complains of itching. From this date improvement continued until the present, when he is perfectly well. Aural pain, at the height of the attack, was such as to cause apprehension of suppurative inflammation. Desquamative nephritis and renal dropsy were marked, but now the urine is free from both albumen and casts; several examinations for a period of many weeks failing to detect either. Hearing same as before attack.

The effect of belladonna, when administered in a sufficiently large dose, is to engender dryness of mouth and pharynx, angina, pyrexia, delirium, convulsions, and coma. The pulse is accelerated, and reaches even 160 or more. Small doses are followed by rise of arterial pressure. This, of course, obtains before paralysis of the sympathetic occurs. Large doses occasion increased pulse rate and diminished blood pressure; the increased rate being due to paralysis of the peripheral inhibitory nerves and *stimulation* of the accelerators, i. e., sympathetic, the diminution of pressure to vaso-motor paralysis. The duplex of belladonna in causing in a small dose rise of arterial pressure is due to *stimulation;* fall, to paralysis. Upon the nervous system this duplex action is still apparent—thus small doses produce delirium (stimulation), large doses convulsions and coma (paralysis).

Minute study of the effects of belladonna demonstrates the fact that of the sympathetic ganglia some are more susceptible to its influence than others; or in other words, belladonna affects certain ganglia powerfully, while others are but slightly influenced. This is especially noticeable in the superior cervical ganglia and by intercommunications and a practical continuity of structure, the ophthalmic ganglion. The same fact obtains in the materies morbi of scarlatina! The former, however, acts by *stimulation*, the latter by *depression*.

Scarlatinal poison in sufficient quantity to affect the vaso-motor system curtails the power of the inhibitory area of Hitzig; belladonna in same proportion stimulates it.

From these facts it seems to me to be clearly proven that when we endeavor to meet a depressing agent that affects the same tract by *depression* as belladonna does by *stimulation*, we possess the rational method of treating this direful disease. That concomitant conditions arise and demand special treatment need scarcely be mentioned: our judgment and skill must serve for this issue.

ABSCESS, ULCERATION AND NECROSIS AS MET WITH IN THE NASAL CHAMBERS.

BY HARRISON ALLEN, M. D.,

Professor of Physiology in the University of Pennsylvania.

Abscess, ulceration and necrosis, as met with in the nasal chambers, present peculiarities which are sufficiently marked to warrant their consideration separately from their occurrence in other parts of the body. As compared to other affections of the nose, they are less frequently seen than is generally supposed, and may on the whole, be grouped among the rare disorders. The following essay is based entirely upon personal observation, and claims to be nothing more than a brief summary of signs, symptoms, diagnosis and treatment.

Nasal Abscess.

Collections of pus in the walls of the nasal chambers are due to furuncle, or to causes connected with disease, either of the jaws or of the teeth.

Abscess of the vestibule, or nasal furuncle, commonly forms about the sebaceous follicles and roots of the seta-like hairs of the nostril at the junction of the ala and the floor. It rapidly develops, and is matured by the third or fourth

day, at which time it forms a rounded sessile elevation at the floor of the vestibule, causing more or less redness and distortion of the nasal wing. The abscess infrequently tends to point outward upon the face. Should the abscess open spontaneously, the pus is observed to be of a thick consistence, and after its escape to leave the abscess wall foul and shreddy. This appearance subsides in a few days and a cure is effected.

Accompanying the development of the abscess there is presented more or less swelling of the corresponding side of the face. Acute pain is felt at the root of the nose, and the angular vein between the internal canthus and the nose is often distended.

Diagnosis.—In the initial stage, before swelling occurs, the pain along the nose and the face simulates, and may be confounded with the pain of neuralgia, especially that of the supra-orbital form. If there is no tumefaction at the nostril, it is difficult to distinguish between the two conditions, since, as has been stated, the pain may be referred to a point remote from the inflammatory focus. The absence of involvement of any branches of the fifth or the seventh nerve, and the announcement of facial and alar tumefaction soon decide the question. In the stage of facial swelling, the general appearance of the parts is identical with that in *alveolar abscess.* Indeed, the two arise from the same cause, namely, œdema and inflammation of the subcutaneous connective tissue. Careful examination of the teeth and gums will easily determine the origin of the swelling. From purulent or cystic disease of the maxillary sinus, vestibular abscess is separated by the acute character of the attack, and by the fact that the canine fossa, which is easily reached by placing the finger above the gum line to the outer side of the eminence of the root of the canine tooth, remains unchanged in the case of nasal abscess, while it is obliterated or has its depression converted into a rounded swelling, in the case of purulent or cystic maxillary disease. Even after the swelling of the suspected abscess is recognized, the differentiation between it and *facial carbuncle* should be carefully made. If pus is not freely formed by the fourth day, or if more than one point of suppuration be detected, or if the inflammatory swelling about the nostril becomes diffused and brawny, or if, in addition to these signs, the angular vein becomes prominent and tortuous, the lower eyelid dusky, and the eye suffused, the diagnosis of facial carbuncle can be made.

Treatment.—The swelling should be freely incised from *within the vestibule* whether pus be present or not. The possibility that the suspected abscess may be the first stage of facial carbuncle can in this way be met, at the same time that the indication for the abscess itself is provided for. In many cases the trouble is insignificant, and requires but little care. In others, on the contrary, where great distress, loss of sleep, and disfiguration are present, rest in bed, the administration of opiates and febrifuges, in addition to the local incision, are demanded. In such cases, as soon as the acute symptoms have subsided, quinia in tonic doses may be given with propriety.

In nasal abscess, other than furunculous, the prodromata are analogous to those of bone or dental disease. Pus may escape into the nasal chamber from an alveolar abscess, though this is an infrequent occurrence. In a case coming under the writer's care, the condition named simulated chronic nasal catarrh of the inflammatory type, and was only distinguished from it by a careful study of the discharge, which, instead of being muco-purulent, consisted of pus mixed with normal mucous. Pus may be confined in a sac of mucous membrane, lying at the floor of the nasal chamber. In a case of this kind occurring in a middle-aged woman, the collection had persisted for fifteen years, had been three times punctured, and had been diagnosed as a cyst of the superior maxilla. The writer opened the cavity along its entire upper surface, and, guided by the direction of a curved probe, which passed toward the mouth, he secured drainage through an opening made between the upper lip and the gum line of the upper jaw. The condition was entirely cured within a fortnight.

Nasal Ulcerations.

Ulcerations in the nasal chamber are of two kinds, septal and turbinal.

Septal ulcerations are in like manner of two kinds, those confined to the mucous membrane and those involving either bone or cartilage.

Ulcers of the mucous membrane.—These are confined for the most part to the mucous membrane covering the triangular cartilage. They are rounded, superficial patches, covered with small blood clots, and thin amber-color crusts. Soreness and dryness of the nose are the principal symptoms complained of, to which may be added occasional bleeding. The edges of the ulcers are not elevated, nor is the general surface depressed. Septal ulceration rarely exists independently and is probably often a sequel of irritation in the turbinal plates. The most obstinate form of ulceration is found in individuals with thin aquiline

noses and narrow nostrils, who are annoyed by a constant sense of irritation in the vestibule. To relieve this, the nostril is constantly wiped with the handkerchief, with the result of exciting a hyperæmia of the parts, which naturally extends to the septal cartilage, and this in turn being the least highly organized of the nasal structures, is apt to become diseased.

This view of the etiology of these cases need not be modified by the fact that the patches are often found on the upper and back part of the triangular cartilage, at a point out of reach of the finger or the handkerchief, since pressure against the cartilage at any point can readily induce congestion throughout its entire extent.

One form of septal ulceration is found only on the maxillary spur, and is the result of picking the nose to remove the crusts accumulated in an unventilated vestibule. The presence of septal ulceration is easily detected by examination through the nostrils. A crust or clot may obscure the exposed patch, but after such coverings have been removed, the characteristic appearances are detected.

The Treatment of the condition is based primarily upon the removal of the catarrhal states on which it depends. The ulcers themselves should be thoroughly wiped with the solid nitrate of silver, or with a saturated solution of the same salt, and the chamber should be closed by the insertion of a pledget of cotton in the nostril. Should these applications fail after two or three trials, a pledget of cotton of sufficient size to occlude the respiratory portion of the nasal chamber should be inserted back of the ulcer. Iodoform should then be packed liberally in the space in front, until the ulcer is entirely covered, after which a second pledget of cotton is placed in the nostril. Should much hyperæsthesia exist, a sixth of a grain of morphia may be added to the iodoform. This application may be repeated every third day. No difficulty need be experienced, as a rule, in curing the ulcers, provided the air about the patient is healthful. A rarefied air, an air charged with alkaline dust, or the air of a furnace-heated house, will sometimes successfully combat all efforts to cure this disease. The writer has known the ulcers to recur after entire recovery, upon the patient's removal to a mountainous country or to the alkali plains of the West. As to furnace-heat, it is perhaps no more irritating to septal ulceration than to any other form of nasal disease, but it is a constantly present factor of interference. The constant use of the nostril pledget can be recommended where a tendency to recurrence of the disease exists.

Septal Ulcers involving Bone or Cartilage.—In a more aggravated form than the one last mentioned, nasal ulceration may exist as a superficial bone-ulcer in the posterior and inferior borders of an opening due to a congenital defect in the septum. Occasionally it is found upon the sides of a perfect septum, either above, near the roof of the vestibule, or more frequently at the floor, near the maxillary spur. In the rare cases of chronic syphilitic disease without necrosis, the ulcer may be serpiginous, and disposed on both the right and the left surface of the septum. The symptoms are almost identical with those of other ulcerations of the mucous membranes.

A tendency to moderate epistaxis is a constant symptom if septal ulceration exists. The parts are, as a rule, covered with a thin dry clot mixed with the crust of inspissated serum. The habit of picking the nose to remove these crusts is early acquired, and to it must be assigned an important role in the prevention of recovery.

The treatment of the condition consists in freely cauterizing the ulcerated surfaces with the galvano-cautery, and after the eschars are removed, in touching the new surfaces with solid nitrate of silver. A cure can be anticipated from the use of these measures, if no specific taint be present.

The congenital septal perforations have been seen by the writer in two places only; namely, in the triangular cartilage directly in front of the junction of the perpendicular plate of the ethmoid bone and the vomer, and in the substance of the perpendicular plate of the ethmoid. They may exist without the knowledge of the individuals possessing them, who report for treatment only when the edges become ulcerated.

In an interesting case referred to the writer by Dr. Albert H. Smith, the edges of a large opening of the kind described, were found to be ulcerated. The idea of the opening being congenital was vehemently combated by the patient, who was thirty years of age, and had suffered but three years with the symptoms of ulceration. The question was then asked, how can congenital openings be distinguished from the acquired ones. The answer satisfied the patient, and may serve to satisfy others making similar inquiry. The acquired perforations are always syphilitic, and co-exist with other signs and symptoms of this disease. Congenital perforations will be found to be associated with other minor congenital defects, for this is the law. In the case referred to attention was directed to the asymmetry of the rugæ of the hard palate, to the unusual elevation of the hard palate, and to the presence of an ex-

ostosis on the line of the inter-palatal suture. In a case of acquired perforation in a person suffering from tertiary syphilis the nasal chambers were found plugged with enormous quantities of inspissated mucus, which occasionally become detached in masses of considerable size, and passing into the pharynx produced most distressing stridor and asthmatic excitement. Removal of the collections gave only temporary relief, and owing to the existence of the opening, plugging either of the nostrils was impracticable. It then occurred to the writer, after the borders of the opening were healed, to insert a vulcanite plate in the opening of the septum. This was skillfully done by Dr. Ed. C. Kirke, a dental practitioner of Philadelphia, and the patient, by the aid of a cotton plug in the nostril, was enabled to close one side of the nose, and thus give the parts rest and prevent the inspissation taking place. By alternating the use of the plug in the right and the left nostril, both chambers were kept free from inspissated mucus, and the patient became almost entirely relieved. The vulcanite plate has now been worn continuously for eighteen months with the greatest possible comfort.

Turbinal ulceration is of much rarer occurrence than septal, and apart from the mention of its occasional syphilitic origin does not demand special consideration. The best marked example of the last-named variety the writer has seen was located on the anterior extremity of the left middle turbinated plate, and was associated with excessive discharge of muco-pus. The external nose was reddened. The ulcer was depressed and vascular, but without pain. Recovery was secured after a treatment of six weeks. In addition to the administration of iodide of potassium and corrosive sublimate, the ulcer was repeatedly touched with the acid nitrate of mercury.

Necrosis.

Necrosis of the bones entering into the nasal chambers occurs in two forms. The most common of these (although relatively rare as compared with other nasal diseases) is an exfoliation from the base of a bone ulcer. It is seen in cases in which the pus from a diseased frontal or diseased maxillary sinus flows over the turbinated bones. The exposure of the bone surface must be, therefore, considered as a sequel of grave bone degeneration elsewhere. The second form is specific necrosis of the septum, turbinated bones, and superior maxilla. In profound changes in the facial structures large masses of these bones may be lost. In the varieties of this form of necrosis met with by the writer the septum has been more frequently involved than the turbinals or the maxilla. The treatment of these cases is simple, for in addition to the administration of anti-syphilitic remedies, nothing is demanded beyond the removal by the forceps of the portions of dead bone if they are detached, or the drilling away of the dead portions if they remain attached to the living tissues. Although complete recovery cannot be anticipated, the purulent discharge and the intensely offensive odor accompanying the presence of dead bone in the nasal chambers can be corrected.

Hospital Reports.

CLINICAL LECTURE.

BY E. G. JANEWAY, M. D.,

Professor of Diseases of the Nervous System and Clinical Medicine, Bellevue Hospital Medical College, New York.

GENTLEMEN: I again present you the young man whom you saw last week, suffering from paroxysms of the respiratory muscles. You will observe that his condition is greatly improved to-day. He says he had but two attacks yesterday, and only one to-day. The treatment had consisted in the administration of arsenic and the use of the galvanic current, but as he did not seem to improve, atropia was substituted in doses of one-seventieth of a grain three times a day, with instructions to increase the amount if necessary. Patients sometimes become accustomed to the use of atropia, and in order to keep up its effects it is necessary to increase the dose. I had an illustration of this fact in the case of an epileptic patient, who had frequently recurring paroxysms, and had been treated by various means, as the taking of nitro-glycerin, nitrite of amyl, the bromides, etc., but without benefit. I advised the discontinuance of these, with the substitution of atropin in about one-sixtieth grain doses. He commenced to improve, but in order to keep up the beneficial effects of the drug, it became necessary to increase the dose as high as one-twentieth of a grain, which amount he is taking at present.

In the case of empyema shown at a previous clinic, and in which a free opening was made, the granulations at the edge of the wound afterward became sloughing, pus was discharged, the temperature rose to 103° F., and the case was beginning to present a very unfavorable aspect. Carbolic acid solution, however, was substituted for the boracic, an iodoform dressing was applied to the wound, and the temperature fell yesterday to 99°.

You will remember that it was my intention at the last clinic to show you a patient in illustration of a certain affection, but it so happened that I was unable to present more than a *post mortem* specimen. By bearing in mind the anatomical features of the specimen then presented, and putting them alongside the clinical history of the

case I shall now bring before you, a valuable lesson may be impressed. This man is an Italian who speaks no English, and the facts in his case are to be derived chiefly from a physical examination. He is thirty-three years of age, and it appears that eleven years ago he had syphilis. As he lies upon the cot, the first thing which strikes your attention is a pulsation observed just below the apex of the heart, and one near the cardiac extremity of the stomach. This pulsation becomes more apparent at a distance by bending pieces of paper a few inches in length at a right angle, and placing one upon either point at which the pulsation is observed, when the perpendicular arms move through an observable space, and in this case nearly synchronously, though not absolutely so. This pulsation is also observable on the left side over the back, on a line corresponding with the pulsation in front. There is some dulness in front, but not such as could not be accounted for by the possible presence of the left lobe of the liver. The patient complains of pain principally on the left side, extending from the back round to the front, in the region of the lower intercostal spaces. It does not extend below the last dorsal vertebra. The tumor, as I have already suggested, is an aneurism, and its location is pretty nearly determined by the region of pain, namely, in the lower part of the thoracic aorta. The pain from which he suffers is doubtless caused in this case, as in the other case, by pressure of the aneurism upon and erosion of the vertebræ, from which the intercostal nerves find exit. I listen for a murmur in this region, but none can be heard while he is lying down. When he sits up, however, a systolic murmur can be heard in front, just below the ensiform cartilage.

Now, I have brought this patient before you on account of the possibility of mistake in the diagnosis. Three conditions might very well suggest themselves as the possible explanation of this case, and it would appear that treatment had been adopted before the patient's entrance into the hospital, pointing at that time to an incorrect diagnosis. The chief subjective symptom from which the man complains is that of intercostal neuralgia, for which in the absence of a careful physical examination the case might be mistaken. Again, Pott's disease would produce very much the same symptoms that we have here, and, moreover, there is another fact which would tend to strengthen the suspicion that such was the affection from which he was suffering, namely, a prominence of a vertebra, corresponding to about the tenth dorsal. You will also observe that as the patient attempts to pick up something from the floor, he avoids bending the spinal column in this region, and allows flexure only at the hip and knee. But, against the view that the case is one of Pott's disease, we find upon careful physical examination a murmur and pulsation which point distinctly to an aneurism. The difficulty of diagnosis between Pott's disease and aneurism in some instances was illustrated in a case in the hospital a good many years ago, in which before admittance a diagnosis of lumbago had been made, and after admittance that of Pott's disease, and the day before the fatal termination of the case, a professor in one of the colleges made use of it as a text for a clinical lecture upon Pott's disease. The following day, while the patient was picking a chicken bone, he suddenly collapsed, and the pleural cavity at the autopsy was found full of blood, due to rupture of an aneurism of the aorta.

As regards treatment, iodide of potassium and slowing of the circulation. The prognosis in these cases of aneurism is, of course, unfavorable. There are but few hopes that a case of aneurism will end in recovery—even if a firm clot should form within the sac. You will remember how the aneurism shown you last week was protected by a firm clot on one side, but that did not save the patient. The general tendency, therefore, is toward rupture and death from hæmorrhage. It is probable that in this case, as in the former case shown you, the hæmorrhage will take place, when it occurs, into the pleural cavity. But we may, perhaps, accomplish some good by iodide of potassium and quiet. I have also found gelsemium in some cases to work very well, as well because of its pain killing character as because of its heart quieting character. The house physician tells me he carried out the idea of gelsemium, but the heart became weak under its influence, and we will now try digitalis instead. Now, digitalis theoretically ought to be bad for aneurism, But I have seen it practically do a great deal of good, and a clot form under its influence, although, of course, a permanent cure was not expected to take place.

I will now present you three male patients, born in Turkey, Arabia, and Bohemia respectively, and whose history on account of their foreign tongue has been but imperfectly obtained.

The appearance of the first patient, the Turk, itself speaks largely for the diagnosis of the case. Notwithstanding his naturally dark skin, it is evident that he is anæmic—anæmic to such a degree as to suggest the idea of leucocythemia; and it was my intention to compare this case this afternoon with one of that disease, had the patient not failed to come. You will observe that the back of the hands are pale, the lips are pale, the tongue is pale, and the conjunctivæ are pearlish. On microscopic examination of the blood, there is found to be decided diminution of the red blood globules, with perhaps a slight increase of the white. Compared with that of one of your number who is in robust health, you will observe a difference in its appearance upon the slide even to the naked eye.

Now, there are two or three things which may be the cause of the anæmia, and which should be borne in mind in any given case. One is, a cancerous process, or any cachectic process, as phthisis, which might by protracted suppuration produce a condition of anæmia. But then the patient is more markedly anæmic than almost any phthisical patient in my wards, and other signs of that disease are absent; nor is there any evidence of cancer. The loss of blood by vomiting, by hæmorrhoids, by bleeding sores, or other means, would account for it, but there is no history of anything of the kind. An examination of the urine shows that he is passing a large quantity daily, the specific gravity is 1010, and quite

a small quantity of albumen was found, but no casts. This might signify chronic nephritis, usually the small contracted kidney, although in a great many cases of the small contracted kidney there is no such anæmia as is seen in this patient. The fact, therefore, that the man has chronic nephritis does not explain altogether his anæmia. Being a Turk, and therefore probably having lived near or in Egypt, we should think of the possibility of an anæmia sometimes seen in inhabitants of that or neighboring lands, due to a small parasite that abstracts blood in the duodenum. But we have no proof of the presence of such a parasite in this case, and that possibility may be set aside. When we consider the kidney trouble, we may say that the anæmia is out of proportion thereto, and I think that in the light of the evidence before us we may look upon the case as one of pernicious anæmia complicating chronic nephritis.

The case of the Bohemian is interesting simply as showing the possibility of mistaking certain dark spots upon the body due to filth for the signs of commencing Addison's disease. The question arose in his case whether the appearances of the skin upon certain portions of the body were not indicative of that disease, but upon further inquiry into his history we learn that he has been a tramp, has been exposed to the weather, is not cleanly, and has doubtless had body lice, which have caused him to scratch in the localities referred to.

The Arabian presented some symptoms which led us to suspect the possibility of a grave form of anæmia, but by rest and care in the hospital, he has become much stronger, and we infer that his anæmic condition was only temporary, due to privation. The three cases afford a good opportunity to study the appearances of an anæmic condition in the dark races.

EDITORIAL DEPARTMENT.

PERISCOPE.

Phtheriasis Pubis.

In the *Med. Times and Gaz.*, Dr. McCall Anderson says this hairy parasite is met with on *all* hairy parts except the head, but the hair on the pubis and neighboring parts is its favorite hunting-ground. It is indeed a very curious circumstance that these three varieties of lice should live in such close proximity, and yet in no case leave their own preserves for the purpose of poaching on those of their neighbors—a trait worthy of imitation by the human species. We can understand how one parasite should prefer hairy, and another non-hairy parts; but it is difficult to see how one pediculus should find its appropriate soil on the head alone, while another attacks all hairy parts except the head. Mr. Quekett's explanation is that the crab-louse, owing to the peculiar shape of its claws, is unable to climb up straight hairs to deposit its eggs, and accordingly selects parts where the hair is curly; but, if so, why should we not encounter it on the heads of curly-headed persons?

Character of the Parasite.—The Pediculus pubis resembles the head-louse in many respects, but its body is much broader and shield-shaped, and there is no distinct separation between the thorax and abdomen. It is studded with small spines, and, besides possessing six feet which resemble those of the other pediculi, it is furnished with eight rudimentary-looking ones, which terminate in bundles of hairs. It does not run about like the head-louse, but grasps the hairs where they emerge from the skin with its forelegs, so that it is very apt to be overlooked, and some difficulty is experienced in extricating it. The nits resemble those of the head-louse, and are attached to the hair in the same way as theirs, but always close to the exit of the hair from the skin.

The itching leads to scratching, and often small papules are developed, which are red and excoriated; and occasionally an eczematous eruption is induced, the cause of which may be suspected from its situation. An examination will then lead to the discovery of the pediculi lying in close contact with the skin, and of their nits, as well as of reddish particles of fæcal matter in the immediate vicinity of the parasites. This affection is met with among all classes of the community, but almost always in adults who have contracted it from others laboring under the disease as the result of impure intercourse, or through the medium of the water-closet.

Diagnosis.—The following points serve to distinguish phtheiriasis pubes from simple pruritis:

Pruritus.	*Phtheriasis Pubis.*
1. Not contagious.	1. Contagious.
2. No parasite to be discovered.	2. Lice, their nits and fæces, discovered among the roots of the hairs.
3. May affect other regions, though not necessarily.	3. Limited to the pubis or neighboring parts, or to other parts provided with hair (always excepting the head).
4. Often a very troublesome affection, and requiring constitutional as well as local treatment.	4. Readily cured by local treatment, *e. g.*, a lotion of perchloride of mercury (gr. ij. to ℥j.)

Eczema complicating Phtheriasis pubis is distinguished from simple eczema by the localization of the eruption, and by the discovery of the pediculi, their nits, and fæces.

The *Acanthia lectularia*, or common bed-bug, remarkable for its reddish color, roundish, flattened form, and offensive odor, resides partly amongst

the bed and body clothing, but principally in crevices in the woodwork of beds, walls, etc., where it deposits its eggs, and whence it sallies forth to feed upon the blood of its victims. It seems not to be met with in South America, Australia, or Polynesia, but is too common in this country in the habitations of the poor, and it is difficult to extirpate it, because it can resist extreme degrees of cold, can live without food even for a year, and hides itself by day.

Its bite produces a swelling like a spot of nettle-rash, but it is distinguished from it by the discovery of the bite in the centre, which, unlike the surrounding redness, does not disappear on pressure. The irritation of the bite, too, as well as the crawling of the parasite upon the surface, is apt to excite nettle-rash over the whole body, which diminishes or disappears by day to reappear at night. The itching is great, and the scratching proportionately vicious, "as the wheals," says Kaposi, "are very large; the two or three middle fingers of the hand are used in scratching, so that the excoriations are apt to be characterized by two or three parallel stripes."

This eruption may be mistaken for that of idiopathic Urticaria (nettle-rash), but in the former the nettle-rash disappears or moderates by day. The bites of the parasites are to be found in the centres of some of the nettle-rash spots, the itching is more intense, and the excoriations are apt to present the characters just mentioned, while a search for the offender will usually clear up the mystery.

The *Pulex irritans*, or common flea, is smaller than the bug; it "is short, shield-shaped, formed of one piece," and its bite is effected by means of "a bristle-like tongue, which is covered by two maxillæ of the form of two sword-blades" (Küchenmeister). The power and elasticity of its feet are very remarkable, enabling it to leap about two hundred times the length of its body, and thus to elude the attempts of its victims to entrap it. Its eggs are about one-third of a line in length, are oval, and of a white color, and are deposited "indifferently on dust and on furniture, and in dirty people under the nails" (Kaposi). It is not so particular as the bug as to climate, although it is said to be unknown in Australia.

Its bite does not produce itching, but it causes a minute hemorrhage surrounded by a bright red inflammatory areola with some swelling; the latter disappears on pressure, but the former does not. The minute hemorrhage passes through the same stages as that resulting from a bruise, and disappears much more slowly than the areola. If the skin is very delicate, as in the case of children, an eruption of nettle-rash may make its appearance, and in that case itching is present. The hemorrhages produced by the bites of the parasite may be mistaken for spots of purpura, from which they may be distinguished by attention to the following points:

Bites of the Pulex irritans (common flea).	*Purpura spots.*
1. Fleas, or their dark brown fæces, detected on the bedding.	1. Not present.
2. Hemorrhages surrounded at first by inflammatory areola.	2. Not so.
3. Spots of uniform size.	3. Not of uniform size.
4. Specially met with where the clothes closely embrace the body.	4. Not so.

The *Acarus folliculorum* was discovered by Henlé in 1841, in the ceruminous, and by Gustav Simon in 1842 in the sebaceous glands. Considerable variations are observed in their size and shape, as well as in the number of their legs—variations which are supposed to represent different stages of development. Even ten or more are sometimes to be discovered in one sebaceous or hair follicle; they lie for the most part lengthwise in the midst of the sebaceous matter, near the surface, and with their heads directed inwards. They are easily detected by squeezing out the contents of the follicle—although they are not found in every one—adding a little glycerine, and examining with a low power of the microscope. They are to be found in the follicles of almost all persons, are not specially associated with any disease, and do not give rise to any symptoms whatever.

Persistent Hiccough.

Dr. James Weaver writes to the *Lancet*, April 7, 1883, the following further particulars concerning his case of persistent hiccough, which we noted some time since:

My patient died on March 13, worn out and exhausted, but otherwise to the last free from an ache or pain, and, with the exception of increased dullness over the posterior portion of the left lung, the symptoms remained almost stationary from the first. When I was called in to see Mr. S——, on the 18th of December, 1882, I found that it was evidently a case of broncho-pneumonia, complicated with hiccough, the latter arising from some unexplained cause. He told me that he had had hiccough more or less since the previous July. He was seen a few days later in consultation, and, although the hiccough was very troublesome, our efforts were chiefly directed to the bronchitis, looking upon the former as a troublesome complication which would soon subside. It did not, however, subside, but went steadily on to the day of his death. On the first of January he was again seen in consultation, and the hiccough was so violent and exhausting that our treatment was somewhat reversed by the remedies for hiccough being brought to the front. It, however, never left him. He was conscious, save an occasional rambling, up to a few hours of his death, and from a state of great mental excitement and anxiety he became perfectly calm and resigned. He slept but very little, and at prolonged intervals, during the whole of his illness, never more than two hours at a time, and was often for days without any sleep. Morphia, chloral, bromide of potassium, ether, etc., only seemed to excite the brain almost to frenzy. The only remedy that did any good in my case was chloroform. I gave it in ten to twenty drops on sugar. I injected it hypodermically with and without atropia, and my patient inhaled it frequently in twenty to thirty drop doses. Some days before the end the patient would occasionally, with great difficulty, raise some thick, very offensive, pus-like matter, streaked with blood.

On March 14, I made a *post mortem* examination. The right lung was much enlarged, and filled not only its proper position, but also extended into the left side of the chest, and so peculiar was the formation that the gentleman who assisted me, at the first glance, exclaimed that there was only one lung. The left lung was so collapsed and solid, like liver, and lying so closely at the posterior part of the chest, that it was completely out of sight. In the right lung there was evidence of diffused bronchitis, and on removing the heart and left lung I became aware of a large mass of scirrhus at the root of the latter, in which were imbedded the pulmonary veins and artery, the veins being partially filled up with masses of scirrhus, and the artery compressed and much smaller than usual. The lung itself was small, hard, and hepatized, but had no scirrhus formation in it. On cutting it across, a dark offensive matter oozed out, and the inner portion was evidently in the early stage of gangrene, being soft, dark in color, and highly offensive. The heart was healthy, as were all the other organs; but on the upper and left side of the diaphragm was a patch about three inches in diameter, rough and hard, covered with millet-seed looking bodies. There were also two small bodies on the anterior portion of the liver. The scirrhous tumor would be fairly represented by a medium-sized orange somewhat flattened at each side, and was no doubt the cause of hiccough either by direct irritation of the phrenic nerve or by reflex action of this nerve through the vagus, the latter more probable than the former, for although the mass was in the direct line of both propositions, yet the phrenic may possibly have escaped by being pushed aside, but the vagus must have suffered from the pressure of such a growth. I must leave it to a better pathologist than myself to say how long such a tumor would take to form.

Dr. Matthews Duncan on Sterility.

In the course of the third Gulstonian Lecture, (*Brit. Med. Jour.*), Dr. Duncan observes:

"It is scarcely an exaggeration to say that, in recent practical works on sterility, there is exhibited entire ignorance or entire neglect of the laws of fertility. Every woman from fifteen to forty-five is regarded as likely to breed. If she be sterile, a cure is at once set agoing; and, if a child be not born, the failure is not debited to the nature of the case, but to the want of ingenuity in the doctor. A reputation for curing sterility is spoken of as if it were founded on substantial claims. The prevalent methods for curing sterility are founded on an implied theory that it in most cases arises from impediments in the way of the spermatozoa reaching the ovum. Without sufficient evidence, strictures are assumed to exist, versions and flexions of the womb are held so to distort the interior passage as to prevent progress of the spermatozoa, cervical catarrh is believed to stop them by mechanical obstruction or by chemically poisoning them; and for these real or imagined evils, sterile women are made the subject of treatment. It is the theory of mechanical obstruction that, by its simplicity and directness, has possessed the profession and the public; and, accordingly, many operations and modifications of operations, and very many instruments, have been devised to do away with the obstruction. The theory has had real rational support in the fact that dysmenorrhœa of a spasmodic kind does, as already shown, frequently accompany the sterility, and in the supposition that the same obstruction which causes sterility by impeding the entrance of semen, causes also dysmenorrhœa by impeding the exit of menstrual blood, or *vice versa*. It has had still more satisfactory support in the observation that the cure of the dysmenorrhœa does occasionally bring with it cure of the sterility.

"The very zeal with which the mechanical theory of sterility has been fostered, and its treatment in many ways pursued, has led to its present decadence, and there is now increased attention paid to other departments of fertility than conception. Especially and justly, the difficulties of naturally starting and healthily continuing pregnancy are brought prominently into view. The mechanical obstruction theory has begun to shrivel, because of the impression produced by the enormous, though inexactly ascertained, proportion of the failures of the attempts to cure founded on it. Even the ignorant sterile women could see that, if this theory of causation were true, there was an easy and plain theory of cure; and they could also see that the failure of the so-called cure was prejudicial to, if not destructive of, the theory. The importance of the difficulties of pregnancy now brought into prominence will, on account of its great reconditeness, be received with no enthusiasm, such as, welcomed the obstruction theory; and the physicians who entertain it can offer no such brilliant prospects of cure to their confiding patients. It is, however, a decided step of progress in a subject of great practical importance.

"It is in Germany that this department of sterility has been chiefly studied, and Grünewaldt of St. Petersburg is its best exponent. Recognizing the importance of this work, I take the liberty of using it to show the great incompleteness of even the most advanced accounts of the subject. For Grünewaldt, sterility is truly never a disease, but a symptom of a disease. Nature has, he says, set no limits to female breeding other than the natural changes in the sexual organs that are observed in the senile state. Sterility is one of the most frequently occurring disturbances of function caused by diseases of the female sexual organs. In these views, and in his whole work, it is implied that sterility depends on disease of the sexual organs, including chiefly endometritis, mesometritis, perimetritis, and parametritis. The difficulties of conception, he says, have only a slight importance, compared with the disorders of the more important vital processes of pregnancy, and these disorders affect chiefly the tissues of the uterus."

Eyesight of School Children.

The *Brit. Med. Jour.*, April 28, 1883, says that a lecture on the effect of reading and writing on the eyesight of young children, was recently given at Berne by Professor Pflüger. The lecturer first called attention to the portentous fact that more than one half of 45,000 children lately examined in Germany were found to be suffering

from defective vision. In some schools, the proportion of the short-sighted was as high as seventy to eighty per cent. whilst, in the Heidelberg Gymnasium, every lad in the school had bad eyesight. This lamentable state of things arose from insufficiently lighted school-rooms, bad print, and bad paper, the method of writing in vogue, and ill-contrived desks and forms. The burdening of children with too many lessons, and the consequent restriction of their hours of play, is a still more potent cause of defective vision. In order to solve the vexed question of the influence of German caligraphy on the eyes of those who adopt it, the Government of Würtemburg, some time ago, appointed a commission, consisting of three schoolmasters and three physicians, to investigate the matter, and make a report. In the opinion of these gentlemen, the mere writing is least among the causes which unfavorably affect children's eyesight. They found that, while comparatively few children write with their backs bent towards the left, fully eighty per cent. give their back, when writing, a right inclination. The latter position tends to produce a permanent elevation of the right shoulder, and ultimately causes curvature of the spine. In the schools they visited, the commissioners actually found twenty per cent. of the boys, and from thirty to forty per cent. of the girls suffering from more or less pronounced curvatures due to this cause. The difference between the two sexes is probably due to the fact that lads, besides being more energetic in play, are more rationally clad than girl scholars. As to position in writing, the distance between the desk and the eyes ought to be about 25 centimètres (nearly 10 inches); yet it was rarely, indeed, that the commissioners met with any children who could keep their eyes at this distance from the paper. Many of them found it necessary to bring their faces within seven centimètres (2.75 inches) of their copy-books. The general conclusion of the commissioners, as of Professor Pflüger, is that of all the evils enumerated, the worst, and those most in need of reform, are the seats and desks at present in use. The Professor further remarked that only ten per cent. of the children examined were naturally short-sighted, and that, as among wild races defective vision is almost entirely unknown, the trouble in question is peculiar to modern civilization and the existing system of teaching. Professor Pflüger expressed the fear that he was like one crying in the wilderness, the prevailing tendency being to lay on the children of this generation still heavier burdens, and to force their minds to the lasting injury of their bodies.

The Diagnosis of Scarlet Fever.

In the *Brit. Med. Jour.*, April 14, 1883, we find a paper on this subject by Dr. J. Spottiswoode Cameron. The author remarked that it was occasionally very difficult to diagnose this disease. Compulsory attendance at school made it especially desirable to recognize every case. He dwelt upon the several symptoms of vomiting, headache, and early delirium; and insisted, when these were present, on an examination of the throat. Enlarged lymph-glands between the ear and the jaw were often of importance in doubtful cases. The tongue, if characteristic, was of value, but absence of strawberry-tongue did not necessarily exclude scarlet fever. Sudden high temperature persisting, typhus and smallpox excluded, generally in a child meant scarlet fever. The rash usually appeared not later than the second day, but he gave cases in which it had been delayed to the fourth or fifth days. In a case with a doubtful history, if he found a tongue with a moist, pale red base, smooth, except that its surface was covered with minute, bead-like papillæ, he should strongly suspect scarlatina: this symptom was, perhaps, the least seldom absent of those characteristic of scarlet fever. This tongue might be found weeks after any pyrexia, but disappeared when there had been no pyrexia. There might be scarlet fever almost without fever, without angina, and without rash. In such indefinite cases, the tongue, the state of the skin, and the urine, were important. Passing to the differential discussion of scarlet fever, Dr. Cameron considered the difficulties presented by a case first seen in (1) the initial, (2) the eruptive, (3) the defervescent, and (4) the convalescent stages of the disease, going over the important symptoms *seriatim* in each step, and showing what light each threw on the differential diagnosis. In the initial stage, measles, diphtheria, smallpox, typhus, pneumonia, quinsy, and simple continued fever might cause difficulty. The history of previous illnesses, the acuteness of the symptoms, the course of the temperature, and the state of the throat, were important. Hospital and drain-throats were apt to be asymmetrical. Ulceration was not common at the beginning of a true scarlatinal angina. A sore-throat in a person who had previously had scarlatina might be infective, as in a case quoted; but diagnosis was generally helped by history of exposure. In the eruptive stage, measles, erythema, rötheln, and even urticaria, might have to be eliminated. In the stage of defervescence, typhoid fever, amongst other diseases, might be mistaken for scarlatina; and in that of desquamation, other febrile symptoms, latent albuminuria, nephritis, and even some skin-diseases, might require to be separated. There was no one sign always present in scarlatina. In doubtful cases, as complete a history of the attack as possible should be obtained; and a percentage of cases would remain in which the only guide to a diagnosis would be a knowledge of the diseased conditions prevalent around.

Congenital Malformation of Both Knee-Joints.

Mr. Hubert Sells, Senior Resident Obstetrician of Guy's Hospital, describes in the *British Medical Journal* the following case of malformation in a new-born infant, very fairly developed:

On looking at the lower limbs, the first thing that struck one was, that the patellæ on both sides were apparently missing, and in their place was, on each limb, a depression. The description of one limb will suffice for both. The movements of the hip-joint were complete. The thigh, instead of being convex, was slightly concave on its anterior aspect. The tibia and fibula were in their normal relative positions. The foot looked forwards naturally, and the ankle-joint was normal. The patella was placed at the back of the

joint instead of in front. In the normal position of the patella was the depression above mentioned, which apparently represented the popliteal space, as the continuation of the femoral artery could be felt pulsating here, and there were some tendons on either side of it, analogous to the ham-string tendons. There was also, running down a little to the inner side of the centre of this space, a strong tendon, which was continued downwards to the head of the tibia, and may have been the representative of the quadriceps extensor tendon. Posteriorly, the patella was rather firmly fixed, nearer the femur than the tibia, in a strong tendon, so that the impression at first was that it (the patella) was attached by osseous tissue to the femur. This idea was, however, dispelled on moving the joint. The movements of the knee-joint were perfect but reversed. The tendon in which the patella was fixed was exactly like the ordinary extensor tendon of the thigh. The artery could not be traced below the head of the tibia. It may, I hope, be seen from the above description, that the leg could be flexed on the thigh anteriorly, as much as it would have been posteriorly in the normal state. When the child was first seen, it had the toes of one foot almost in its mouth, which, of course, it could reach easily without flexing the thigh. The child died on the third day after birth, and, unfortunately, the parents would not consent to a *post mortem* examination.

Chloroform Breath in Gastric Disturbance.

The French correspondent of the *Medical Press* (April 18, 1883,) says:

There is a symptom of gastric disturbance in children which I have never yet seen mentioned in any text-book, French or English, and yet it is almost invariably constant and generally to be met with at the *début* of the affection, so that it may be considered as a sure premonitory sign, I mean that of the breath, which smells as if the child had freely inhaled chloroform. I have always found that this "chloroform breath" not only commenced with the gastric disturbance, but continued during the whole period of the malady, and that its cessation indicated also a cessation in all the other general symptoms, fever, vomiting, etc., and consequently a return to health. I have remarked this peculiar odor in children of every age, and once in a grown-up person; it was then very strongly marked. I do not pretend bringing to light anything new, but I have never heard this peculiar symptom alluded to anywhere. In gastric derangement or *embarras gastrique*, as the French call it, the breath has always been described as possessing a heavy odor, but that is very different from the chloroform smell which is sometimes so pronounced as to be liable to induce the medical man to believe that the patient had been using the anæsthetic.

Another correspondent writes to the same journal (April 25, 1883) as follows:

As a corollary to your French correspondent's remarks in last week's *Medical Press*, I may mention that this phenomenon is not confined to gastric disturbance. It is at times common immediately after sexual connection, and during the act a naturally foul breath may become quite sweet and of a distinct chloroform odor. The explanation is to me a mystery, but I am *positive* as to the fact.

Puerperal Septicæmia.

Dr. W. N. Bryant concludes a paper on this subject in the *Boston Medical and Surgical Journal*, May 3, 1883, as follows:

I. Puerperal septicæmia is a strictly infectious disease, depending upon the absorption of a specific *materies morbi*.

II. The infecting material may come from without or be developed from within the patient.

III. It is amenable to treatment, which should always have for its first object thorough local disinfection.

IV. It is a preventible disease, and to this end the utmost care should be used by all attendants upon puerperal women to guard them from infection from without, while a systematic course of antiseptic uterine washes should be given night and morning in all lying-in cases for the first ten days following delivery.

Reviews and Book Notices.

Notes on Current Medical Literature.

——Among new journals one of the most noteworthy is *The American Psychological Journal*, a quarterly, edited by Dr. Joseph Parrish, and published by P. Blakiston, Son & Co. It is well printed on good paper, and makes a neat number of 112 pages. The National Association for the Protection of the Insane and the Prevention of Insanity issue it. Price, $2.00 a year.

——*The Quarterly Therapeutic Review* is the title of a trade publication issued by Baiss Brothers & Co., Jewry street, London. Price, one shilling.

——In a neat reprint, Dr. Henry O. Marcy, of Boston, discusses the best modern methods of treating operative wounds. The paper was first read before the American Academy of Medicine at its meeting in this city.

——The question of the pathology and morbid anatomy of tubercle is discussed in an article by Dr. N. Senn, of Milwaukee, in a reprint of thirty-four pages. It contains also a good bibliography of the subject.

——In the Department of Sanitary Literature we have received the "Proceedings of the Sanitary Council of the Mississippi Valley, 1883," the "Proceedings of the Illinois State Board of Health, 1883," the "Seventh Report of the Board of State Commissioners of Public Charities of Illinois," and the "Fifth Annual Report of the Connecticut State Board of Health for 1882." The last mentioned is a handsome volume of 400 pages, with maps and a number of special reports on subjects of sanitation.

——A convenient 12mo. "Manuel des Injections Sous-cutanées," by Drs. Bourneville and Bricon, has been published by De la Haye & Co., Paris, pp. 171.

——The ordinance proposed for this city with reference to house draining, etc., has been published by P. Blakiston & Co., 1012 Walnut street, (price, 10c.) and is worthy the consideration of sanitary students.

——The subject of trichinæ and trichinosis is well handled by Dr. W. C. W. Glacier, of the Marine Hospital Service, in a pamphlet of twenty pages, (price, 25c., Illustrated Medical Journal Company, Detroit, Mich.)

——The valedictory address to the graduating class of the Jefferson Medical College was delivered this year by Prof. J. M. Da Costa. It is on "The Higher Professional Life," and is replete with those true and noble views of professional duty and thorough appreciation of the dignity of professional work which have always been well marked in the productions of this admirable writer.

——An interesting study of the various forms of bacteria has been recently made by Dr. T. J. Burrill, of Champaign, Ill. (8vo. paper, 50c., pp. 65). Its contents are as follows: Part I. "Nature and Organization of Bacteria." (1) Existence, (2) Color, shape, size, (3) Movement, (4) Structure, (5) Reproduction and development, (6) Vitality and endurance, (7) Nutrition, (8) Origin, (9) Place in nature. Part II. "Effects of Bacteria." (1) Fermentations and putrefactions, (2) Diseases, (3) Benefits. Part III. "Classification of Bacteria." Sixteen genera (with artificial key) and over one hundred species systematically arranged and described.

——In a reprint describing his last year's work in ovariotomy, Dr. Wm. Goodell, of this city, reports the results of twenty-five cases. Of these six died, but, as Dr. Goodell very correctly observes, this mortality must be balanced by the fact that in not a single instance did he decline to operate. Many ovariotomists do not state in how many cases they decline to operate for fear of ill results.

BOOK NOTICES.

Therapeutic Handbook of the United States Pharmacopeia. By Robt. T. Edes, M. D., etc. New York; Wm. Wood & Co. 8vo., pp. 397.

The plan of this work is to take up the articles in the U. S. Pharmacopeia, *seriatim*, and give their therapeutic action, doses, immediate and remote effects, and in what diseases they are particularly indicated. The sources of the author's information are the Dispensatories and the leading treatises on materia medica. The physiological and toxic actions of drugs come in for a share of attention, and a number of non-officinal drugs and preparations are discussed in a similar manner at the close of the volume.

The author has performed his task with care, and his collation has been sufficiently thorough not to omit anything of much importance, although he has added but little to what may be found in the last editions of the Dispensatories.

In connection with the publication of this book by the Messrs. Wood & Co., we remark that what appeared to be the unfair and dishonorable action of the Committee of Publication of the U. S. Pharmacopœia in giving its publication to that house has not yet been explained. (See REPORTER, January 27, 1883.)

The Diseases of Women. By Heinrich Fritsch, M. D. Translated by Isidor Furst. New York: Wm. Wood & Co., 1883.

The author is Professor at the University of Halle, and writes a condensed practical treatise in a plain and direct manner. The translator has done his part satisfactorily, giving a fair English dress to the author's German. There are a number of wood engravings, but like most of those in Wood's Library of Standard Medical Authors, of which this is one volume, they fall short of what is desirable in point of clearness and careful printing.

A Manual of Auscultation and Percussion: Embracing the Physical Diagnosis of Diseases of the Lungs and Heart, and of Thoracic Aneurism. By Austin Flint, M. D., etc. Third Edition. Philadelphia: H. C. Lea's Son & Co. Cloth, 8vo., pp. 242.

This convenient hand-book has proved very acceptable to the profession, and it unquestionably merits its popularity. Dr. Flint writes clearly, and while he does not go into the tedious and unnecessary minuteness of the German and French Auscultators, he tells all that is of real importance on his subject. The present edition has been carefully revised by him, and has been brought up to the latest advances of diagnostic art. It will no doubt continue to be appreciated by the studious public.

—An illustration of stinginess is cited by an Arkansas editor, who knows a man that talks through his nose in order to save wear and tear on his false teeth.

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THE DRAINAGE PROBLEM.

Old as the hills, yet ever new, the question of drainage is still in an unsettled and unsatisfactory condition.

It seems that we are altogether on the wrong tack, and that nothing short of a great sanitary revolution can set us straight.

From the mother country we are commencing to hear a great deal about the "pollution of rivers," and it will not be long until the same cry is heard in our own land.

The system of drainage of cities into water courses seems fundamentally wrong, yet it is the plan almost universally resorted to.

Let us take Philadelphia, to illustrate. Most of our drainage, of our rotten, poisonous refuse, flows into the Delaware river. This river is subject to tidal influences; as the tide falls the refuse is carried towards the sea, as it rises it is brought (a goodly portion, at least,) back towards the city; day by day, this foul mass flows down and up, each twenty-four hours, adding greatly to that already in the river.

That this refuse does not pass out to sea, and that it does not subside to the bottom of the river, will be satisfactorily demonstrated to the optic and olfactory nerves of any one who will take the trouble to visit our river front.

Now comes the hot sun of summer; the surface of the water is vaporized under its influence, and some of this poison is carried up with the vapor; when the wind blows from the east, north-east, or south-east, this pestilence-breeding vapor is wafted over our city and into our houses. Do you wonder where epidemics come from? Do you want any further explanation of *so-called* malaria?

As we say, each twenty-four hours adds to this contamination, until, in time, if it is not now, the Delaware river will become one large uncovered sewer.

The famous Delaware river shad are caught at Gloucester, (six miles below Philadelphia); some people eat them and become sick, and wonder why fish make people sick. Is it any wonder? Is it not rather matter for surprise, that we are not all down with blood-poisoning?

The purifying influences of the atmosphere, we fear, are inadequate to render innocuous such enormous masses of refuse as are daily discharged from so large a city.

Our remedy lies in disposing of our waste as nature intended that we should. Horses, cows and dogs do not use water-closets; their refuse is spread sparsely over the soil, which it feeds and enriches.

Organic refuse must go where it belongs, to nourish lower organic life.

We do not mean to deprecate the use of water-closets: they are necessary conveniences to our present state of civilization; but what we mean is that instead of carrying our refuse into water courses, we should cause it to accumulate, in suitable localities, remote from the cities, where it can be utilized in the manufacture of manure.

One of our leading sea-shore resorts is about to introduce such a system of drainage, and they calculate that the sale of the refuse in the shape of manure will pay all the expense of maintaining this system of drainage.

When we have succeeded in educating the public up to the point of realizing the value of preventive medicine, then, and not till then, can we hope that they will understand that money spent for sanitary purposes, is money just as well spent as are the large sums consumed in the erection of unsightly and unnecessary public buildings.

THE INSANE COLONY AT GHEEL.

A correspondent of the *Boston Medical and Surgical Journal* (May 3, 1883), furnishes a very interesting account of a visit to the town of Gheel, which argues much for the advocacy of non-restraint in the treatment of the insane.

Gheel is within an hour's ride of Antwerp, and on one of the direct routes from Berlin.

At the time of his visit there were 1600 insane patients living around as inmates of the families of the colony, and in almost every case they were absolutely free from restraint.

One-half of the sane inhabitants of the town are employed in taking care of their insane fellow creatures, for which they receive pay from the government sending them or from friends or the patient himself, varying from $60 per year for paupers, to $100 to $1200 for wealthier patients.

The colony is under the charge of a medical director and his assistants, who appoint the families to take care of the insane, this privilege being considered in the light of an honor, for which all strive. The patients are separated according to the degree of their malady: the most quiet and curable are located in the centre of the village; those somewhat troublesome, but offering hope of recovery, are located not far from the centre of the village, and to them is held out, as an inducement for good behaviour, a prospective removal to the more desirable location.

The idiotic children are congregated in a hamlet where special educational advantages are furnished, although they associate freely with other children.

The town is divided into five sections, each of which is presided over by one of the assistant physicians, whose duty it is to make the round of his section once a month, while the director must visit the entire colony twice in the year. Each section is also under the charge of a non-medical "guard," an officer who has the general management, including the enforcement of sanitary regulations. A peculiarly quiet and orderly air pervades the town, which seems to result in part from the natural character of the inhabitants, and in part from a spirit of emulation among them, all wishing to be considered worthy of obtaining and keeping *pensionnaires*. The question naturally arising as to the effect on the normal mind of this constant and familiar association with the insane was answered by the statement that no more insanity exists among the permanent inhabitants of Gheel than among those of other places of its size, and that many families have handed down this occupation through generations without sign of nervous or mental affection appearing among their members.

While apparently doing as they please, the patients are carefully and intelligently watched.

The date at which Gheel began to be devoted to the care of the insane is hard to determine. It

may with certainty be placed as early as the twelfth century, and legend carries it to a much earlier period.

Judging from the account given, this town is well worthy of a visit from all traveling physicians.

THE PARIS MUNICIPAL LABORATORY.

The necessity for similar institutions in our large cities will be apparent when it is realized that during last year out of sixty-two samples of butter examined, only eleven were pure. Preserved vegetables showed the presence of copper in eleven out of thirty-five samples. Milk was found to contain oatmeal, dextrine, white of egg, sugar, brain matter, oils and fat. Wines showed oxide of lead, alum, salt, salicylic acid, and sometimes arsenic in liquids colored with fuchsin. Beer showed picric acid, gall, aloes, colocynth, cocculus indicus, cubeb mixed with nux vomica, and carbonate of sodium, strychnia, box leaves, juniper, etc. Even *residues* of *fecula manufactories* were found in some adulterations.

This laboratory was erected in 1881, and only costs about $26,000 per annum, divided as follows:

1 Director of the Laboratory	$1,200
1 Sub-Director	900
1 Analyst (1st class)	480
3 Analysts (2d class), $360 each	1,080
16 Inspectors (1st class), $525 each	8,400
16 Inspectors (2d class), $360 each	5,760
3 Employés, Porters	1,000
General Expenses	960
Total	$19,780

The rest of the money is applied to the purchase of instruments, books, etc.

Tradesmen, whose places of business are pointed out as those in which adulterated articles are sold, are visited by two officers (inspectors). They request to be allowed to examine the products on sale, and do so, both microscopically and chemically, on the spot, with the means they carry with them. If an article appears to be adulterated, two samples, one for examination at the laboratory, the other to be preserved in case of dispute, are taken, and attested by the signatures of the tradesmen and both officers. Suspected samples can be lodged at the nearest bureau of police, where they are placed in a special chest for the purpose, and forwarded to the laboratory at the prefecture of police, by means of the prison van. Every article that enters the laboratory is analyzed quantitatively, the result, however, being only made known to the sender on payment of a fee varying according to the nature of the substance, from five to thirty francs. It is upon the figures obtained in this analysis that the chief of the laboratory bases his opinion. Each analysis is registered in a book for the purpose, which remains at the laboratory and forms part of an important collection.

Such laboratories in our large cities would be productive of much good, and would be a wise way in which to spend a portion of the public money.

SOMETHING PRACTICAL ABOUT MICROCOCCI.

"I care not," said a gentleman the other day, who is well known for the practical nature of his contributions to medical science. "I care not whether micrococci are the cause per se, or whether they are the vehicles carrying the cause of zymotic diseases, but I do know one thing—they possess great prognostic value."

He then went on to describe his belief in the following proposition: That in scarlet fever, measles, puerperal fever, and the like, when a microscopic examintion of the blood demonstrated the presence of large quantities of granular matter (call them micrococci, or whatever you choose), the prognosis is very bad.

This matter, he believes, acts mechanically, it obstructs the capillary circulation, causing the formation of heart-clot, and death from mechanical interference with the circulation.

In support of this view, he cites numerous instances where this granular matter has been found in the blood, when, after death, enormous clots are found in the right ventricle, while the left ventricle is found firmly contracted, dying in systole, failing to overcome the mechanical obstruction offered by this granular matter in the capillaries.

When he finds this condition under the microscope, his prognosis is grave, and *vice versa*.

The discoloration of the skin, found after death in these so-called malignant cases, he considers due to this capillary stasis.

Still further, and what is of greater moment, he is convinced that alcohol possesses great power to alter this morbid condition of the blood. "Make your patients drunk, if you can, but you will find that the tolerance of alcohol in these cases is something wonderful. I used to use carbonate of soda and digitalis, and I lost my patients; I now use whiskey, and I save them." As soon as he has reason to suspect a grave case, from the severity of the symptoms, he commences to use alcohol and pushes it to the stage of intoxication, and he has had most excellent results.

Our authority is so well worthy of confidence that we would be glad to have his recommendations heeded and to have our readers give the alcohol treatment of grave zymotic diseases a fair trial.

It is truly refreshing in these days of ponderous, wordy, theoretical, micrococcal discussions, to have some reliable authority tell us something truly practical about them.

Notes and Comments.

An Obscure Affection of the Feet.

When Dr. John McIntyre, Medical Officer of Health for Avoca Circle, S. Natal, Africa, first entered upon his duties, he was extremely puzzled by a curious affection of the feet, which he found peculiar to the Coolies, Europeans and Kaffirs never suffering from it. They complained of excessive tenderness and heat or burning in the plantar surface of the feet. They professed not to be able to walk, and sometimes even to stand. They were generally weakly and debilitated, but how far this might be the result of the inconvenience from the feet he could not tell. The temperature was normal, and, except that they were weak, there was nothing he could find to confirm their statement regarding their feet. Thinking it might be in some relation to specific disease, he tried iodide of potassium; then he tried tonics—quinine, iron, cod-liver oil, arsenic, local embrocations, etc. No treatment seemed to influence the feet in the least. At last he thought he would try the effect of nerve-stretching. He cut down on the posterior tibial nerve and stretched it. The first few cases were much relieved, but after he had tried this treatment on four or five with apparent benefit, he began to pull the nerve in both directions much more forcibly than in the first cases, and since he began to do so all the cases so treated have been entirely free from the heat and tenderness in the feet, and the general health has also improved. In some of the cases it is over three years since he so treated them, and they have had no return of the tenderness and heat.

His communication appears in the *Lancet*, April 28, 1883.

Six Years' Experience in the Treatment of Syphilis.

Dr. Charles R. Drysdale thus concludes an article on this subject in the *Med. Press*, April 18, 1883:

The treatment of syphilis, commencing with the initial lesion, ought to be continuous, and should consist of very small doses of some mercurial salt, continued for months. When severe symptoms are seen, inunction, calomel vapor baths, or fractional doses of the mercurial salt should be given for a week or so every four hours, in combination with large doses of the iodide of potassium, sodium, or ammonium. Atropia drops should be frequently used in iritis. In gummy deposits the chief curative remedy is iodide of potassium in large doses; but a tonic dose of some form of mercurial salt may be added as a germicide. If cerebral symptoms supervene, they are to be treated energetically with the iodide and with immersion.

Mercury in such small doses seems to do no harm to the general health, and there is much evidence to show that it is a tonic, which may be given even for years with advantage in some cases of anæmia. All cases of syphilis, mild or severe, should be treated by these small doses of mercury in order to prevent the supervention of tertiary symptoms or gummy products. The germ of syphilis has not yet been seen by the microscope, but it exists in all probability, and this is the rational account of the useful action of mercury and iodine, which are both germicides.

Hysterectomy.

Dr. G. Graville Bantock in the *Lancet*, April 14, 1883, says that we should never dream of resorting to oöphorectomy in a case of pediculated fibroid or large multiple fibroids. Experience has already shown it to be useless in these two classes. "But that there are certain cases in which oöphorec-

tomy should take the place of hysterectomy I am free to admit. Such a case is that of a small or very moderately sized intramural fibroid; in such a case oöphorectomy will, I believe, render us good service, and should be preferred because of its small risk. But when the tumor is large, I believe oöphorectomy to be as dangerous as, and in some cases even more dangerous than, hysterectomy has now become under improved methods of performing the operation."

Ear-Ache in Children.

Dr. Samuel Sexton contributes an article on this subject to the *Medical Record*, May 5, 1883, in which he deprecates routine treatment or injections until we have found out the cause of the ache by careful examination, for in a very large number of the earaches in childhood the causes are to be sought elsewhere than in the hearing organ itself, and they will be found to depend, for the most part, on nervous sympathy; the most prominent are dentition, dental caries, and colds in the head. Thus nervous impulses propagated from regions remote from the ear may give rise to pains in the ear—neuralgic otalgia—without perceptible hyperæmia; or the intensity of the congestion arising in a part so richly supplied with blood-vessels may manifest itself as an acute aural catarrh.

To Abort a Stye.

Dr. Louis Fitzpatrick, who has recently returned from Egypt, where all kinds of eye affections are extremely common, writes to the *Lancet*, April 21, 1883, that he has never seen a single instance in which the stye continued to develop after the following treatment had been resorted to: The lids should be held apart by the thumb and index finger of the left hand (or a lid retractor, if such be at hand), while the tincture of iodine is painted over the inflamed papilla with a fine camel's-hair pencil. The lids should not be allowed to come in contact until the part touched is dry. A few such applications in the twenty-four hours are sufficient.

Vertigo.

In the beginning of a communication on this subject by Dr. Edward Woakes, in the *Brit. Med. Jour.*, April 28, 1883, the author says:

The point of view which I propose to submit for consideration in this paper is, that all vertigo is essentially auditory in its seat; that is to say, whenever the symptom of giddiness, disturbance of the equilibrium, defective gait, falling, or whatever modification of these may characterize the symptom of vertigo, its immediate occurrence is due to a modification of tension of that part of the labyrinthine fluid contained in the semicircular canals, and the appreciation by the ampullar nerve-apparatus of this change of tension.

Erythematous Eruption in Enteric Fever.

Two cases of enteric fever, in which there occurred a scarlatiniform eruption, causes Dr. Whipham to ask in the *Med. Press*, April 18, 1883, whether these are really cases of double poisoning, of mixed scarlet and entric fevers. The absence of desquamation, and the fact that an erythematous eruption is not uncommon in variola, pyæmia, and other forms of pyrexia, led to the conclusion that there are really instances of enteric fever preceded by erythema and not mixed cases of scarlatina and enteric fever.

Glycerine in Skin Disease.

M. Desguin, of Anvers, has given glycerine internally in certain forms of skin disease with, it is said, marked success, especially in acné punctata and the furuncular diathesis. He commences with four drachms daily and gradually increases the dose. He states that the secretion of the cutaneous glands, which is thick and irritating in these diseases, becomes more liquid, and cutaneous irritation is notably lessened. During convalescence from scarlet fever, he believes that it facilitates desquamation.

A Case for Venesection.

Dr. A. C. Shout reports in the *Brit. Med. Jour.*, April 28, 1883, the case of a young man, who, for some days, had been suffering from a fullness in the head, that rendered his gait unsteady. He fell into a canal, and when seen was lying on his back. His wet clothes removed, body warm, skin dry, breathing slow, face and neck swollen and congested: pupils semi-dilated, and jaws firmly locked; pulse 100, and comatose. Venesection was performed to the extent of thirty ounces, when he slept for two or three hours and awoke perfectly well.

Nephroraphy.

Dr. David Newman, of Glasgow, has just performed this operation for the first time in Great Britain. The *Lancet*, April 28, 1883, says of it:

The patient is a female, who suffered from floating kidney, which Dr. Newman determined to treat by fixation. The kidney was reached from behind, its capsule stitched to the edges of the

incision, and several deep button-sutures were passed through the tissues and kidney-substance. The patient has recovered satisfactorily, and is now quite relieved of her former pain.

Spina Bifida.

In the *Brit. Med. Jour.*, April 14, 1883, Mr. Robson, referring to the case related by him in a former issue (see p. 415), and in which he had transplanted periosteum from a rabbit, reported that no new bone had been formed, but he thought the periosteum had helped to thicken the spinal coverings. A new principle in the operation was the treatment of the meninges by bringing together the serous surfaces, after the manner of modern peritoneal surgery.

Chylocele of the Tunica Vaginalis.

Dr. Wm. M. Mastin, of Mobile, reports a case in the *Annals of Anatomy and Surgery* for May, 1883. He considers the morbid condition much less infrequent than either the literature or the numbers of the recorded cases would suggest, and believes that a more careful examination of many so-called cases of hydrocele will substantiate this statement. The treatment he advises is free incision into the sac and ligation of the ruptured and leaking duct.

Carbolized Iodoform.

The following formula is given by C. Sherk (*Berliner Klin. Wochenschrift*) as a great improvement over iodoform:

℞.—Iodoform,	10 gr.
Acid, carbolic,	5 gr.
Ol. menth. pip.,	2 drops.

The acid is to be rubbed up with the iodoform, and the peppermint oil added subsequently. The disagreeable odor of the drug is completely covered, and it is not again developed even at an elevated temperature.

Belladonna in Gonorrhœa.

Dr. J. Numa Rat states in the *Lancet*, April 7, 1883, that he has treated a few cases of mild gonorrhœa successfully by smearing the penis with ointment of belladonna, and enveloping it in a cloth smeared with the same. No injections were used nor internal medicine employed, and the cure was complete in a week.

The Micrococcus of Cerebro-spinal Meningitis.

Herr Leyden demonstrated this micrococcus before the Berlin Society for "Medicine," on February 19 (*Med. Press*, April 2, 1883). He concludes that there can no longer be any doubt as to the parasitic nature of cerebro-spinal meningitis. He has found in the exudation liquid of meningitis the same cocci as had been met with in pneumonia, and he has likewise proved the existence of the cocci in a case of pyocephalus.

Aneurism of Both Popliteal Arteries: Cure.

In the *Brit. Med. Jour.*, April 7, 1883, Dr. Samuel Gordon relates the case of a man upon whom, in 1817 (at the age of 29), Mr. Todd tied the left femoral artery for aneurism of the left popliteal, with a perfect cure. In 1820 the same operation was performed on the right side, with a like result. Thirteen years later, the patient died from cancer of the stomach.

Iodine an Antidote for Snake Bite.

Dr. George H. Carpenter, of Moorefield, W. Va., writes to the *Medical News*, April 21, 1883, that he has secured excellent results in two cases of poisoning by the bite of the copperhead, from the internal administration of tinct. iodini comp., fifteen drops in a third of a glass of water, and the local application of the tincture of iodine to the bitten limb or part.

Iodoform in Diabetes.

From the *Gaz. degli Ospitali*, February 4, 1883, we learn that in two cases of diabetes mellitus, Bozzolo has used iodoform (30 grains daily) with good results. In both cases the quantity of urine was decreased; in one (mild) the glycosuria entirely disappeared; in the other (severe), it was lessened.

Popliteal Aneurisms.

From the Sussex County Hospital (*Lancet*, April 7, 1883), is reported one case of popliteal aneurism cured by instrumental compression of the femoral, and one case cured by manipulation and rest.

Albuminuric Retinitis of Pregnancy.

Dr. A. Emrys-Jones calls attention to this condition in the *Brit. Med. Jour.*, April 14, 1883. The prognosis he considers good, so far as vision is concerned, though sometimes patches of choroidal atrophy remain, which considerably diminish the acuteness of vision. For treatment he recommends iron in some form and extra care. He hopes that this note will induce practitioners to take careful notes of the presence of albumen during pregnancy, and the effect on the labor itself, and on the general health of the patient afterwards.

CORRESPONDENCE.

Tænia Medio Canellata in Three Members of a Family.

EDS. MED. AND SURG. REPORTER:—

Last October Mr. R. came to my office, wishing me to relieve his thirteen-year-old daughter of a tape-worm. I advised him to first bring me some of the proglottides as soon as they should be passed. He was able to demonstrate them to me in a short time, and I now prescribed for her as follows: Take to night for supper nothing but oatmeal or barley gruel, and take nothing else whatever before retiring but a cup of absinth tea made of one drachm of the herba absinthii. On rising in the morning take 2½ drachms ext. filicis maris æth. and two minutes after ½ oz. ol. ricini, which passes the extract quickly into the gut. Half an hour later take another cup of the absinth tea the same as the night before.

The next day the father brought the tape-worm, head and all, in a bottle. He stated that it passed without trouble at half-past eight, one hour after the tea was taken, and that the girl was feeling a little weak, but well otherwise.

In January last the mother of the above case came and stated that she also had a tape-worm. I prescribed at once for her the same treatment, but in larger doses. She took a half ounce of the ext. male fern and two drachms of the herb in each cup of tea.

In April, the 14-year-old son came with the same statement. I prescribed for him the same as for his sister.

The effect was in all cases the same, and in the same short time, without any bad consequences, and the above treatment has never failed me in any case.

When Mr. R. brought the last specimen, he thought he would rather not have any more raw beef in his family after this. They had always freely indulged in it, contrary to my advice.

J. H. VOJE, M. D.

Fredonia, Ozaukee Co., Wis., May 7, 1883.

NEWS AND MISCELLANY.

West Virginia State Medical Society.

The Medical Society of West Virginia convened in sixteenth annual session in the court house at Grafton, May 16, the President, Dr. B. W. Allen, of Morgantown, presiding. Prayer was offered by Rev. Robinson, of the Baptist Church.

Dr. W. L. Grant, chairman of the Committee of Arrangements, made an address of welcome on behalf of the committee, and Hon. John W. Mason, on behalf of the Mayor and citizens of the city, welcomed the Society to Grafton in an eloquent and well-timed address, which was received with hearty approbation by the members.

The first Vice President, Dr. Grant, of Grafton, was called to the chair, and the President delivered his address.

Dr. Allen, among other things, advocated the establishment of a full Medical Department in connection with the State University.

Dr. R. W. Hall, of Mannington, from the Committee on Climatology and Epidemics, presented an interesting report of several epidemics that have occurred in different parts of the State during the past year. This report gave rise to an animated discussion on the subject of typhoid fever, that was opened by Dr. Reeves, and participated in by Drs. Stover, of Richmond, Landis and Baldwin of Ohio, and Gerstell, Jepson, Lazzell and Carpenter, of the Society. The prevailing opinion seemed to be that the disease may arise *de novo*, that it is not contagious in the common acceptation of that term, that many cases recover with but little treatment except the most careful nursing and attention, and that bad symptoms may be often successfully combated with proper medicines. A preamble and resolutions were introduced by Dr. Reeves commending the good done by the Library of the Adjutant General's Office and the Army and Medical Museum at Washington, and calling upon Congress to keep the two united under one control and to secure for them fire-proof buildings, and an annual appropriation that shall be adequate to their support.

Several other unimportant matters were acted upon, when the session closed until half past eight o'clock the next morning.

The committee of arrangements provided splendidly for the entertainment of the members.

In the evening at half past seven o'clock a lecture was delivered by Rev. W. A. Shipman, of the Lutheran church of Grafton; subject, "Materialism."

At nine o'clock a grand ball was given in honor of the Society.

After the lecture the Society was entertained at a ball given in its honor at Brinkman Hall.

The Society reconvened at 8:30, on the 17th, with an increased attendance. Resolutions were offered by Dr. Morgan, of Clarksburg, providing for the establishment of a medical journal to be under the control of the Society, with the aid and co-operation of the State Board of Health.

On motion of Dr. Jepson, the resolution was referred to the Committee on Publication, with instruction to report on the subject at the next annual meeting.

Dr. A. F. Stifel, on behalf of the Committee on the Brock Prize, reported that no paper had been placed in the hands of the Committee.

Dr. J. Frissell read a paper entitled "Health." The paper contained so much information of value to the people, that it was referred to the State Board of Health, to be published in their reports, in order that it might have a much wider circulation than if reported in the transactions.

Dr. J. P. Birney and J. T. Warder were elected to membership.

Dr. Vankirk introduced a resolution which was adopted, commending the work of the National Board of Health, and calling upon Congress for appropriations to enable it to continue its good work.

Dr. Lazell read a paper on new remedies.

A paper by Dr. Myers, on the Germ Theory of Disease was read and referred; also a paper by Dr. Morgan, of Clarksburg, on the Abuse of Ergot in Obstetrics.

Remarks were made on the subject by Drs. Landis, of Ohio; Stover, of Virginia; and Morgan and Gregg.

Dr. Carpenter read a paper entitled Insanity as a Disease, and the Duty of the Medical Profession of the State in regard to it.

It was discussed by Drs. Baldwin, of Ohio, Reeves, Kunst, and Howell. The latter offered the following resolution, which was adopted:

Resolved, That a committee be appointed by the President of the Society, whose duty it shall be to collect statistics and general information relative to the management of the insane, and report to this Society at the next annual meeting.

Under this resolution the following committee was appointed: Dr. G. H. Carpenter, chairman; Dr. Fleming Howell, of Clarksburg; Dr. A. H. Kunst, of Weston; Dr. Allen Gettings, of Weston; Dr. G. H. Moffat, of Parkersburg; Dr. A. F. Stifel and Dr. J. B. Reed, of Wheeling.

The following amendment was made to the By-Laws: No member shall occupy more than twenty minutes in reading of a paper before the Society. If the paper prepared is too lengthy to be read within its limit, it may be read by abstract, the paper in form being referred.

The following resolution offered by Dr. Lazzell was adopted:

Resolved, That the Secretary be authorized to purchase twenty-five copies of the Code of Ethics of the American Medical Association for distribution among new members.

Dr. S. L. Jepson read a paper entitled "Puerperal Fever," with special reference to its treatment by intra-uterine antiseptic injections. The doctor warmly advocated this as a valuable therapuetical measure to the treatment of this disease, and made reference to cases in which it had been used with great success.

After remarks by Drs. Landis and Morgan, the paper was referred.

The Society adjourned to meet at Clarksburg.

Action of the Medical Society of Harford County, Md.

In Memory of Dr. Silas B. Silver, May 8, 1883.

Dr. Silas B. Silver died at his residence, "Silverton," in Harford county, Md., on April 1, 1883, of chronic disease of the heart, induced by inflammatory rheumatism. Dr. Silver was born near his late residence on February 20, 1815, and was 68 years of age at the time of his death. He was a pupil of the celebrated Dr. Joseph Parrish, of Philadelphia, and graduated in the medical department of the University of Pennsylvania in 1838. He was quite successful in his early practice, and acquired considerable reputation as a physician; but his health failing, he was compelled to retire from active practice many years ago.

Dr. Silver was ever active in upholding the honor and dignity of the medical profession, and was particularly active in the organization in 1866, and in the subsequent support of the *Medical Society of Harford County, Md.* Although not engaged in the practice of the profession for several years previous to his death, he was, nevertheless, a regular attendant upon the meetings of the society whenever his health permitted, and always expressed sound and conservative views upon the subjects discussed. The *Medical Society of Harford County*, at its recent annual meeting, held in Bel Air on May 8, 1883, unanimously adopted the following resolutions, which were prepared and offered by Drs. Forwood, Lee, and Hopkins—the committee appointed by the President—as in some degree expressive of the loss sustained by the Society in the death of Dr. Silver:

Whereas, The sad visitation of death has invaded our body, and again reminded us of our mortality by the extinguishment of the vital flame of our friend and professional collaborator, Dr. Silas B. Silver; therefore be it

Resolved, That we, the members of the *Medical Society of Harford County*, in meeting assembled, while submitting to the inevitable—to the laws of nature and to the will of God— do, in sadness and sorrow, sincerely grieve over the loss of an active and useful member of our society, whose efforts were largely instrumental in its organization, as they were also exerted toward the elevation of the standard of medicine, and in the cultivation of the amenities of life between professional brethren.

Resolved, That while experiencing our personal pain in the loss of our fellow and friend, we are still mindful of, and sympathetic with, the sorrow of his immediate family circle; and that we do hereby tender our most profound respect and hearty sympathy to the devoted wife, who so faithfully and so tenderly ministered to every want of the suffering invalid through his long and painful illness; and who now in her widowhood must bear the storms of life without his sheltering arm and love.

Resolved, That a copy of these resolutions, designed to express our esteem and respect for our departed member, be presented to the widow of the deceased; and that copies of the same be offered for publication to the Philadelphia Medical and Surgical Reporter and to the *Maryland Medical Journal*, and also to the newspapers of Harford county.

Dr. Forwood, a life-long friend, and one of the attending physians of Dr. Silver in his last illness, delivered an eulogium upon the life and character of the deceased, and also explained the peculiarities of the patient's disease, and the course of treatment adopted.

Dr. W. W. Hopkins next spoke in terms of high respect of the personal and professional acquirements and standing of the deceased—the friend and cotemporary of his father, the late Dr. Thomas C. Hopkins—of his deep interest in the Medical Society, and of his dignified and unblemished personal character.

Dr. Lee also added a few words in commendation of the services of the deceased—of his professional integrity, and of his valuable services to the Medical Society.

Upon motion, the Society then adjourned to meet in Bel Air on the second Tuesday in November.

W. Stump Forwood, *Secretary.*

Illinois State Medical Society.

The meeting was called to order in Peoria on Tuesday, May 15, at 10 o'clock, by the President, Dr. A. T. Darrah, of Bloomington, Ill.

After prayer by Rev. J. C. Bruce, the chairman of the Committee of Arrangements, Dr. John Murphy, made a brief address of welcome, to

which Dr. Wm. Hill, of Bloomington, responded.

Dr. J. E. Owens read the report on "Surgery."

Dr. Prince, of Jacksonville, showed an apparatus for distension of the bowel.

Dr. J. S. Whitmire showed a new truss for hernia.

Dr. N. Holton read a short paper on dislocation of the left kidney.

Dr. Crummer, of Warren, read a report on a case of deformity from effects of nerve injury.

REPORT OF NOMINATING COMMITTEE.

The committee was organized by electing Dr. N. S. Davis chairman, G. W. Jones secretary.

The following is the report of the committee:

Mr. President and Members of the State Society.

Your Nominating Committee have the honor of presenting the following names of gentlemen as suitable for officers, and recommend their selection for the positions to which they are severally assigned for the ensuing year:

President—Prof. Edmond Andrews, Chicago.

First Vice President—David S. Booth, Sparta.

Second Vice President—Geo. W. Nesbitt, Sycamore.

Treasurer—Walter Hay, Chicago.

Secretary—D. J. Jones, Chicago.

Members of the Judicial Council for three years—Robert Boal, Peoria; Herbert Judd, Galesburg; L. G. Thompson, Lacon.

Committee on Practical Medicine—J. C. Frye, Peoria; J. W. Hensley, Yates City; N. S. Reed, Chandlerville.

Surgery—Roswell Park, Chicago; D. S. Booth, Sparta; J. D. Whitley, Petersburg.

Obstetrics—S. R. Crawford, Monmouth; Ellen A. Ingersoll, Canton; C. DuHadway, Jerseyville.

Gynecology—W. S. Caldwell, Freeport; L. H. Corr, Carlinville; A. F. Rooney, Quincy.

Ophthalmology and Otology—J. P. Johnson, Peoria; Robert Tilley, Chicago; P. H. Garrettson, Macomb.

SPECIAL COMMITTEES.

J. V. Black, Jacksonville, on Oral Surgery.

Dr. Christian Fenger, Chicago, continued for another year.

W. G. Ransom, Roscoe, continued.

C. Truesdale, Rock Island, on Tetanus.

M. F. Bassett, Quincy, on Vaccination.

J. P. Matthews, Carlinville, on Diseases of Children.

A. Wetmore, Waterloo, on Physiology.

COMMITTEE ON ARRANGEMENTS.

D. W. Graham, Chicago; Chas. Gilman Smith, Chicago; R. C. Hamil, Chicago; H. A. Johnson, Chicago; E. Ingals, Chicago.

Society will meet next year at Chicago.

Items.

—1430 graduates from our various reputable medical schools this spring. What will become of them?

—Injection of a nevus with perchloride of iron produced immediately fatal results in a surgical clinic at Chicago, recently.

—Lycopodium can be put to an excellent use when sprinkled over oiled silk. It prevents the fabric from adhering together.

—A German patent has just been taken out for the manufacture of bottles, etc., from cast iron, containing 12 per cent. of silicon, a compound which is said to resist action of the strongest acids.

—Sounds from the consulting-room.—"How long will it take you to cure me, doctor?" "Well, Mr. Blank, I think you can get back to your desk at the bank in about a month, but you will have to remain under treatment for several years." "But you mistake; I am not Mr. Blank the banker, but Mr. Blank the letter-carrier." "Oh, that alters the case. There is nothing the matter with you but a little biliousness. You will be well in a month!"

OBITUARY NOTICES.

WILLIAM FARR, M. D., C. B., F. R. S., D. C. L.

The father of English vital statistics is dead; he to whom the civilized world owes the present system of statistics upon which all our vital calculations are based, has passed away. He died April 14, aged 75 years.

QUERIES AND REPLIES.

EDS. MED. AND SURG. REP.—Under the "Scott Law," lately passed by the Legislature of this State, no person is able to obtain alcoholic liquors except on the *prescription* of a physician. A patient comes and asks for *a prescription* for some whisky, or brandy, or what not, and says: "I always use it when I become so-and-so," or, "It is the only thing that will do my wife any good when she has a cold," or, plainly, "I like to have a little about the house to use when I need it." Ought I to write him a *prescription* (?) for what he asks for, without further ado? Would it be a *prescription?* Would it not be evading the law, even though I feel assured that he will not use it abusively?

Will you describe the method of obtaining carbonic acid water by means of siphon, referred to by W. B. Atkinson in the *Quarterly Compendium* for January?

I ordered gr. 1-20 doses of belladonna for a child of three years, once a day, at bed time. Each dose caused a brisk and copious purgation within two or three hours of taking. Is that common, or did it depend on idiosyncrasy?

Hilliare, Ohio. P. F. JEWELL, M. D.

1. Unless the use of alcohol is indicated as a drug by the patient's condition, a physician prescribing it would be evading the intention of the law.

2. You can buy it at any good drug store.

3. The dose is a *little* too large for a child of that age, though it should not act as you describe, unless under some peculiar idiosyncrasy.

MARRIAGES.

PERRY—THOMAS.—On April 26, 1883, at the First Baptist Church, by Rev. George Dana Boardman, D. D., Dr. Safford G. Perry, of New York city, and Miss Frances S. Thomas, of Philadelphia.

DEATHS.

JONES.—In this city, on the morning of the 3d of May, at his residence, No. 200 Washington avenue, John William Jones, M. D., in the seventy-fourth year of his age.

SHRADY.—Suddenly, April 29, Mary Lewis, wife of Dr. Geo. F. Shrady, of New York.